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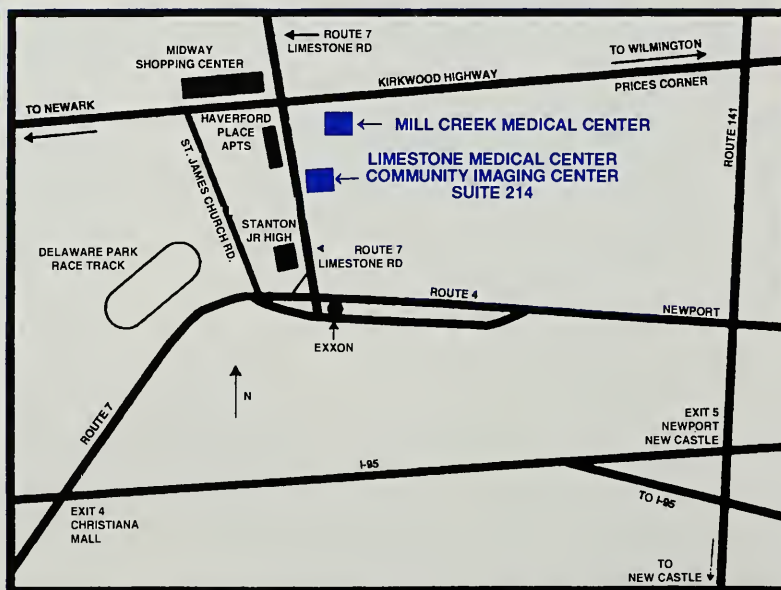
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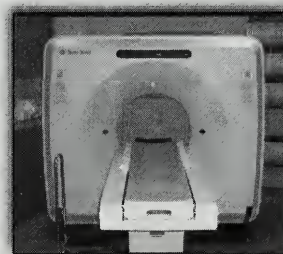
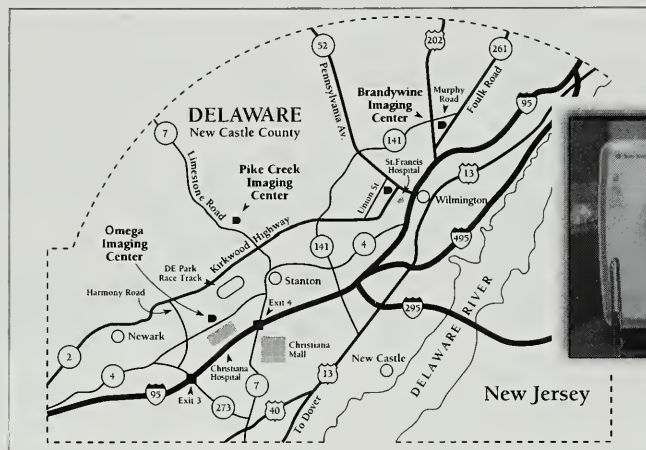
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Preventive Medicine What can we do about it?

Martin G. Begley, M.D.

Preventive medicine is a recurring "hot topic" in the media, and it's sometimes used as a bat to beat the medical profession. Cantankerous pundits criticize physicians for ignoring it, the Clinton White House healthcare taskforce used to talk as if they invented it, and HMOs claim they provide it. This bleating and bellowing has been uninformed, misguided or disingenuous and has been followed by academics wheedling millions of government grant dollars for research that misses the target. It's unfortunate; because preventive medicine is an important component of medical practice, and the public is not served by this gale of glib gab on the subject. We physicians must retake the lead on this issue. The following are some thoughts to expand discussion of it here in Delaware.

First, we have to clearly define the term "preventive medicine." Often what is characterized as preventive medicine — mammography, pap smears, PSA and cholesterol level determinations — is really early disease detection, not preventive medicine. Only maneuvers that protect an individual from developing a disease process should be called "preventive." There are only two: vaccination and healthy lifestyle.

This observation is not meant to discourage patients from obtaining screening examinations. In fact, we need to promote them more vigorously as only about half of the women who should get mammograms and pap smears do so. Fewer men get PSA determinations and even fewer of either gender obtain cholesterol levels.

However, distinguishing between early detection or screening examinations and preventive medicine is important for several reasons. First, it focuses more public and professional attention on true prevention. Currently, mammography receives justifiable praise and much publicity since it will discover a woman's breast malignancy early. However, by contrast, much less publicity informs women of the mountain of evidence showing that a low fat diet can prevent the development of this disease and eliminate the surgery, chemotherapy and physical and emotional pain a woman must endure to survive cancer. The same is true of heart disease. There's lots of publicity reminding you to check your cholesterol levels so you don't die before your time. There's much less encouraging exercise that will keep you alive. (Another important note: there is strong evidence that exercise decreases mortality from all causes, not just cardiovascular disease.)

There's a second reason to keep a sharp distinction between screening and preventive interventions; it forces honesty. That honesty is hard to come by because preventive medicine requires resources, work and personal commitment that few want to allocate. Insurance companies boast they have preventive medicine programs offering for evidence statistics only on how many of their subscribers get screening exams. Health benefits managers have been duped by this data. What these managers and their companies need to know is what the insurer is doing for employees who are obese, sedentary, smokers, or substance abusers. These behaviors cause most health problems sickening a work force. Such statistics should be demanded especially from insurers who claim to

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, DE. He is the president of the Medical Society of Delaware.

be "HMOs." Then there would be industry focus on what is consequential, and pertinent information available to consumers in search of a health plan. The medical insurers would also ultimately save money and improve their viability as companies. Instead, insurance company CEOs strive only to grab quick profits to fatten their compensation packages at the expense of quality for subscribers and long term value for investors. The prescient observation a NIH colleague of mine made ten years ago when he remarked, "The term 'Health Maintenance Organization' is an oxymoron," is very true.

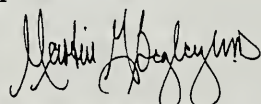
The academic community has to be kept honest as well. With the exception of a few studies on vaccination programs, most of the money earmarked for research on preventive medicine has been used to evaluate early detection programs. Studies of lifestyle optimization usually document the lack of it in practice and offer neither analysis of nor solutions to the problem.

Why are the really important issues of preventive medicine too often circumvented? You don't need to complete medical school to answer that. Getting people to improve their lifestyle can be frustrating, even maddening. People tend to do darn well what they please thank you, despite the benefits of doing otherwise. Those in the media and politics who pontificate on what they perceive as medicine's failure to provide preventive medicine should appreciate this. Especially since, for most of them, a peek in the mirror would make it obvious that it isn't easy to get people to lose weight and exercise. The perfect example is a well-known critic of medicine whose family wealth, and power as a senator from Massachusetts, give him unlimited access to the best of medical care. Yet, while he has exhorted mightily for more preventive medicine, his great girth lends considerable weight to the argument that responsibility for this issue can't be placed only on physicians.

We have to develop honest and effective approaches to preventive medicine and more of the health care dollar must go to prevention, less to pedants and profiteers. Meanwhile, physicians can still do some things to improve preventive medicine. The following are some ways I have collected from reading, colleagues and experience.

1. Keep encouraging patients to be healthy: Too few physicians do so (e.g. only 40 percent of physicians advise their smoking patients to quit). Furthermore, since repetition is essential for all learning, including learning lifestyle changes, repeat your advice-without nagging.
2. We can't get into a battle of wills: People naturally desire independence and respect, and instinctively resist what they see as coercion or condescension. They respond best to gentle encouragement. Battling with them is counter-productive.
3. Look for what will motivate an individual: A few will be moved by longevity statistics. More will improve their lifestyle to look good in a bathing suit.
4. Wrestle noncompliance with a tag team: If every physician who sees a smoker encourages him to quit, he may get the message. I have had some success with patients I saw only for an angiography consult.
5. "Let's walk the talk": To change, patients need words and example. Admittedly it is very difficult for physicians to find time for exercise. But we need to. The long hours, on-call time, critical responsibilities and difficult decisions we face in our practices make for a very unhealthy lifestyle. Our striving to live better will give our patients inspiration, and us empathy with them. It also insures our health and effectiveness.
6. Expect success: Doing otherwise invites failure. Furthermore, there will be successes. Mr. John Taylor, the editor of *The News Journal*, is a well-known and excellent example. Two years ago he announced that he was going to stop smoking and he has!

Finally, we will do more to improve preventive medicine for Delawareans if we count the worth of a physician not in the number of cures achieved, but the number of happily healthy days his or her patients' live.



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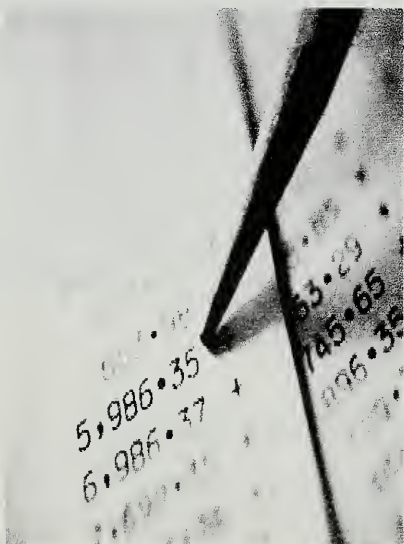
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Effects of the Flutter Device on Pulmonary Function Studies Among Pediatric Cystic Fibrosis Patients

Raj Padman, M.D. — Dawn M Geouque, B.S., R.R.T.
Matthew T. Engelhardt, R.P.F.T., C.R.T.T.

ABSTRACT

Purpose: Previous studies have shown that the Scandipharm Flutter® airway clearance device has increased the ability of cystic fibrosis patients to expectorate mucus. Studies that show the effects of the Flutter on pulmonary function among the pediatric cystic fibrosis patients are limited. Thus, we embarked on a study to assess the device's effectiveness.

Methods: The long-term effect of the Flutter on pulmonary function tests (PFTs) was studied and compared with other airway clearance techniques, such as chest physiotherapy (CPT) and Vital

Signs, Inc. 9000 PEP™ positive expiratory pressure (PEP) therapy for cystic fibrosis patients of five to 17 years of age with mild to moderate disease. Of the 15 patients who qualified, six completed the study. The patients were evaluated using PFTs and a respiratory assessment at the beginning and end of each new therapy. Duration of each therapy was one month.

Results: No respiratory assessment parameters changed between the therapies studied. All patients who used the Flutter preferred it over the other two therapies. The patients stated they felt better clinically, were able to expectorate mucus more easily, and felt more in control of their therapies. Paired t-test statistical analysis from the PFT data indicated no significant changes in forced expiratory volume in the first second of expiration (FEV_1), forced expiratory flow from 25 percent to 75 percent of the loop (FEF_{25-75}), airway resistance (Raw), or specific airway conductance (sGaw) among the three therapies studied.

All authors work at the duPont Hospital for Children in Wilmington, Delaware.

Conclusion: This study has shown no significant change in respiratory assessment parameters or pulmonary function. Further studies involving multicenter trials are warranted to evaluate the effects of the Flutter on pulmonary function.

INTRODUCTION

Cystic fibrosis (CF) is the most common serious autosomal recessive disease among Caucasians.¹ The CF community hopes for a cure for this disease with research focusing on gene therapy.² Until cost-effective therapy is widely available, comprehensive treatment of CF patients includes methods directed at slowing the progression of pulmonary disease. The cornerstone of pulmonary therapy has been antimicrobial agents and mucus clearance. The past primary technique has been postural drainage (PD) with chest physiotherapy (CPT) and vibration to assist mucociliary clearance.³ Because this conventional treatment modality is both time-consuming and labor-intensive, other techniques and devices are gaining acceptance. A device that has become more widely used is a small hand-held device, called the Flutter, from Scandipharm, Inc. (Birmingham, AL). This device is designed to facilitate mucus clearance in patients with hypersecretory lung disorders. Studies on the efficacy of this device to clear mucus from the airway of CF patients are limited.⁴ The amount of mucus production has been shown to be enhanced by the Flutter when compared with the techniques of CPT/PD.⁴ There have been limited studies measuring the improvement in lung function with the Flutter; therefore, our study objective was to evaluate the Flutter and compare its effect on pulmonary function among pediatric patients with the effects of CPT/PD and positive expiratory pressure (PEP).⁵

BACKGROUND

A 1993 study showed that use of the Flutter markedly improved patient clinical signs such as coughing, mucus expectoration, dyspnea, breath sounds, and the general medical condition.⁴

Cystic fibrosis patients were studied to determine the amount (by weight) of expectorated sputum and compare it with the amount produced by vigorous voluntary coughing and CPT/PD combined with vibration. The amount of sputum expectorated after using the Flutter was three times the amount expectorated by the two other therapies.⁶

An abstract from Italy showed use of the Flutter device as an independent therapy was as effective as caregiver-dependent CPT/PD in enhancing sputum production.⁷

A 1994 study showed use of the Flutter improved pulmonary function in patients with hyperproductive asthma. The patients involved in the study also stated a subjective improvement in pulmonary function.⁸

EVALUATION METHODS AND PATIENT SELECTION

The Flutter is a hand-held device (Figure 1) that enables the patient to be independent of another caregiver for therapy. This promotes compliance and independence. Two other therapies studied for comparison were CPT/PD, which requires a caregiver to perform the therapy, and PEP, a mask device with a pre-set pressure that can be used independent of a caregiver.

The specific aims of the study were to determine if the Flutter will improve or maintain pulmonary function and to learn the effects of the Flutter on oxygen saturation, sputum production, and breath sounds.

INCLUSION CRITERIA

The study was approved by the Institutional Review Board.

For inclusion in the study, the patient had to meet the following criteria: between five and 21 years of age, mild-to-moderate cystic fibrosis (defined by

Figure 1. A transparency of the Flutter Device



the Schwachman System for Clinical Evaluations of Patients with Cystic Fibrosis), productive cough, no hospitalizations during the month prior to the start of the study, clinically stable at the first visit (as determined by our respiratory assessment), and ability to perform standardized pulmonary function studies.

STUDY DESIGN

A comparison of the Flutter's effect on pulmonary function tests with the effects of CPT/PD and the PEP therapy was studied among 15 clinically stable CF patients between five and 17 years of age with mild-to-moderate disease. They were seen as outpatients. Each patient was arbitrarily assigned to one of three groups of randomly sequenced therapies: PEP, CPT/PD, or Flutter. The patients served as their own controls. Each therapy was performed for 15 minutes, three times a day, for one month. Chest physiotherapy and postural drainage was used between the therapies to return each of the patients to his or her baseline status. At the end of the study, each group had participated in all three therapies. There were no changes made in their established medication regimen. Pulmonary function studies were performed at the beginning and end of each new therapy using MedGraphics 1085D Body Plethsmograph Unit (St. Paul, MN) and Pf/Dx Pulmonary Function System,TM (St. Paul, MN). A basic respiratory assessment, which included respiratory rate, heart rate, oxygen saturation level, breath sounds, cough (productive vs. nonproductive), and current medi-

cations, was performed at each visit. Each patient was asked to complete a home tracking log and bring it to each outpatient visit.

Patients could be excluded from the study for hospitalization for acute pulmonary exacerbation during the month prior to start of study, a history of noncompliance with previous therapies, current hemoptysis, or severe pulmonary disease.

Patients were withdrawn from the study for hospitalization during the study; development of hemoptysis; and noncompliance, which was determined by patient tracking logs and follow-up telephone calls done by respiratory care practitioners.

RESULTS

Of the 15 patients who qualified for this study, five were excluded because of hospital admission for acute pulmonary exacerbation, and four withdrew themselves. Six completed the study. An average percentage of change in forced expiratory volume in the first second of expiration (FEV_1), forced expiratory flow from 25 percent through 75 percent of the flow volume loop (FEF_{25-75}), airway resistance (R_{aw}), and specific airway conductance ($sGaw$) were analyzed for CPT/PD, PEP, and Flutter (Table 1). Paired t-test statistical analysis from the pulmonary function data indicated no significant changes in the parameters studied for the three therapies (Table 1). No significant changes were noted on clinical examination. Oxygen saturation remained > 95 to 96 percent on all patients. Only a tendency towards higher saturation, 97 to 98 percent, was seen post-PEP therapy. All patients stated they felt physically better, were able to expectorate mucus more easily, and felt more in control of their therapies.

DISCUSSION

For the last half-century, the cornerstone of successful treatment of CF has been aimed at reducing airway obstruction, controlling airway infection, and improving nutritional status.

Table 1: Results of the pulmonary function data comparing the three therapies

		FEV ₁ [*]	FEF ₂₅₋₇₅ ^{**}	Raw [†]	sGaw ^{††}
Mean SD [#]	CPT ^{##}	5.6	28.7	27.6	46.8
Average % change	CPT	6.25	18.28	-12.95	26.89
Mean SD	PEP [‡]	5.2	23.1	27.9	43.2
Average % change	PEP	7.74	31.68	-17.81	24.08
Mean SD	Flutter	9.6	20.9	26.9	21.7
Average % change	Flutter	3.66	11.61	11.3	-8.25

^{*}FEV₁ = forced expiratory volume in the first second of expiration
^{**}FEF₂₅₋₇₅ = forced expiratory flow from 25%-75% of the flow volume loop
[†]Raw = airway resistance
^{††}sGaw = specific airway conductance
[#]SD = standard deviation
^{##}CPT = chest physiotherapy
[‡]PEP = positive expiratory pressure

Tenacious purulent secretions in airways are the most prevalent feature of CF. Clearing the airways of these secretions has been an important component of CF therapy for more than 40 years.

More definitive therapies directed at basic defects, including manipulation of ion transport, activation of mutant cystic fibrosis transmembrane conductance regulator (CFTR) protein, and gene therapy are now on the horizon. Until these treatment modalities become more widely practiced, symptomatic therapy is crucial to improve survival of the CF patient.

Several studies have demonstrated the benefit of CPT/PD for CF.⁹⁻¹² An extensive review of CPT has recently been published.¹³⁻¹⁴ Postural drainage with chest percussion and vibration, manually or with a mechanical percussion, constitutes the traditional chest physiotherapy.

At least as effective are newer alternative airway clearance techniques, such as autogenic drainage, active cycle breathing, and other techniques that

rely on controlled breathing and build-up.¹⁵⁻¹⁷ Flutter, high frequency chest oscillation (Therapy Vest),¹⁸ low and high pressure positive expiratory pressure devices,¹⁹⁻²² and intrapulmonary pressure devices²³ are increasingly being used as airway clearance techniques.

The Flutter does not require expensive cumbersome equipment, and it does not require a partner. The authors feel it is simple and safe. The patient independence this newer device allows makes it likely that it could

supplant traditional therapy in CF patients who are old enough to master the technique. The only restrictions are that the patients cannot be too ill to cooperate and the disease cannot be localized and require intensive concentration over a particular lung lobe or segment. Children as young as four or five years of age can use this alternative technique.

Specific airway clearance techniques and devices need to be individualized for each patient based on effectiveness and compliance. No single technique is suitable for all patients.

CONCLUSIONS

Although previous studies have shown increased mucous expectoration using the Flutter, this study showed no significant change in respiratory assessment parameters or pulmonary function. Patient tracking logs were felt to be fairly accurate in ascertaining if patients were using techniques as prescribed. However, it is possible that variations

in compliance performing any one of the airway clearance techniques may have affected our results. The patients demonstrated a great deal of interest and enthusiasm initially with the new therapies, Flutter, and PEP. Questions raised by the study include: 1) Did the novelty and interest of the therapies become exhausted as the study progressed? 2) Did the patients miss the participation of their caregivers during CPT/PD?, and 3) If patients were more compliant, would the results of the study have been altered? Further studies that include a larger number of patients and involve multicenter trials are warranted to evaluate the effects of the Flutter on pulmonary function studies and, possibly, answer the above questions.

PRODUCT SOURCES

Testing Devices:

- Flutter, Scandipharm, Inc., Birmingham, AL
- 9,000 PEP™, Vital Signs Inc., Totowa, NJ

Pulmonary Function Systems:

- MedGraphics 1085D Body Plethsmograph Unit, St. Paul, MN
- Pf/Dx Pulmonary Function System,™ St. Paul, MN

ACKNOWLEDGMENTS

The authors thank Scandipharm, Inc., Birmingham, AL for providing the hospital with six Flutter devices for our study.

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ACE Inhibitor/CHF Interim Report West Virginia Medical Institute

Edward R. Sobel, D.O.

The analysis upon which this publication is based was performed under Contract 500-96-P603, entitled, "Utilization and Quality Control Peer Review Organization for the State of Delaware," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this publication does not necessarily reflect the views of or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged the identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcome.

Several months ago, the *Journal* published an article written by me and entitled, "The Use of ACE Inhibitors for Congestive Heart Failure Among Delaware Medicare Beneficiaries" (*DMJ*, Vol. 70, No. 4, April 1998, pp. 193-196). This article emphasized the need to improve the care delivered to Medicare patients by adopting practice patterns derived from research by the Agency for Health Care Policy and Research (AHCPR). These patterns could improve survival and the quality of life for patients with Congestive Heart Failure.

The article showed the baseline frequency of five major quality indicators being used at that time in the hospital for the care of these patients: 1) the use of ACE inhibitors at discharge, 2) the receipt

of written discharge instructions regarding medications, etc., 3) instructions regarding the monitoring of weight gain, 4) instructions given to patients on proper diet, and 5) the instruction of a follow-up visit within two weeks of discharge with the physician. (*Editors note: Vol 70, No. 4 of the DMJ also contains an editorial written by Peter V. Rocca, M.D., which addresses these quality indicators.*)

Initial findings of the study, which were released in February of 1997, indicated significant opportunity for improving care. Since the release of that initial report to each of the hospitals in Delaware, much work has been done looking at care processes. Several of the hospitals undertook major multidisciplinary studies and have initiated significant changes in their care plans which are now at various stages of implementation. Ideas were shared by all of the Delaware hospitals at a WVMI

Edward R. Sobel, D.O., is the Principal Clinical Coordinator for the West Virginia Medical Institute. He is also a member of the Medical Society of Delaware.

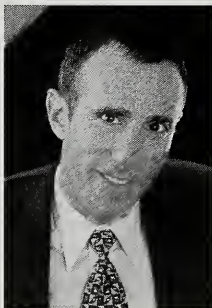
Quality Conference held this past Spring. This article provides an interim report of the progress that was made from the initial release of the findings until remeasurement during the period of December 1997 to February 1998.

Even though full development of these hospital-based care plans, which are often comprehensive and include care management of heart failure on the inpatient as well as the outpatient side, has not yet been achieved, there has already been significant improvement in each of the indicators. ACE inhibitor use among eligible patients has risen from 54 to 74 percent at discharge. Documentation of essential discharge instructions on medication has risen from 43 to 98 percent. Documenta-

tion of weight monitoring has risen from four to 18 percent. Discharge dietary instruction has gone from 40 to 80 percent, and the documentation of the recommendation for physician contact within fourteen days has gone from 25 to 68 percent.

The West Virginia Medical Institute is very pleased to see these significant interim increases in the quality of care. We are continuing to work with the hospitals as they implement their guidelines and pathways. We encourage all physicians who treat patients with Congestive Heart Failure to examine not only care of their inpatients, but also those cared for at the office to see if maximal treatment is regularly offered to each patient.

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Screen Medicaid Children for Lead Poisoning When They are Most at Risk

Russell Dynes

The Health Care Financing Administration (HCFA) is revising Medicaid policy for screening children for lead poisoning as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The definition of EPSDT services includes the provision of laboratory tests, including a blood-lead level assessment. Medicaid policy on lead screening has historically been based on the recommendations and guidance from the Centers for Disease Control and Prevention (CDC). The CDC has recently published new guidance on lead screening and HCFA has determined that Medicaid policy should be revised to be consistent with CDC guidelines.

Medicaid policy is being changed to require a blood-lead test for every Medicaid-eligible child at 12 to

24 months of age. A blood-lead test is also required for any Medicaid-eligible child 36 to 72 months of age who has not previously been tested for lead poisoning. Any additional blood-lead tests should be provided based on a provider's medical judgment, as well as any medically necessary diagnostic and treatment services coverable under Medicaid.

While there has been a decline in the average blood-lead levels of children in the United States as a whole, children in low-income families, children receiving public assistance and children who reside in urban areas continue to be at greatest risk of exposure to lead. Many of these children who have elevated blood-lead levels are not being screened and not receiving follow-up treatment. The revised Medicaid policy reflects the need to comprehensively screen Medicaid children for lead poisoning at the ages they are most at risk.

Russell Dynes is the Project Director for the Delaware Health and Social Services' Childhood Lead Poisoning Prevention and Health Systems Protection programs.

Medical Society of Delaware Alliance

1998 Holiday Sharing Card

*Happy New Year to all of our friends in the
Delaware Medical Community!*

Joseph and Virginia Arminio

Mehdi and Llyn Balakhani

Magdy and Amira Boulos

Michael and Elaine Bradley

Michael and Kay Burkhardt

John and Robby Chabalko

Christopher and Joan Donoho

Thomas and Joan Fiss

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Richard and Jane Henderson

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Tom Mieszala and Carol Tavani, M.D.

Paul and Deborah Montigney

Walter and Jane Moore

William and Nanci Newcomb

Peter and Linda Panzer

Jonathan and Kelly Saunders

Stephen and Paula Wetherill



These families have generously contributed to one of the following funds: The AMA Foundation, Delaware Medical Education Foundation, or the DIMER Fund of the Delaware Health Care Commission. Contributions to these funds are accepted throughout the year. Contact the Medical Society of Delaware Alliance for more information.

Proceedings of the 1998 House of Delegates Part I

The remainder of the reports considered at the House of Delegates meeting will be published in the February 1999 issue of the Delaware Medical Journal.

The complete report of the Proceedings of the 1998 House of Delegates is on file at the Medical Society office and is available to members.

The 209th Annual Meeting of the House of Delegates of the Medical Society of Delaware was called to order at the Delaware Academy of Medicine Building, Wilmington, Delaware, on Friday, November 20, 1998, at 1:30 p.m. by Stephen S. Grubbs, M.D., President, Medical Society of Delaware.

A quorum was declared.

A motion was made, seconded, and approved to adopt the Proceedings of the 1997 session.

The session included remarks by Richard F. Corlin, M.D., Speaker of the House of Delegates of the American Medical Association; recognition of other special guests and past presidents of the Medical Society of Delaware who were present; reports of the Reference Committees; Dr. Grubbs' address

as President of the Medical Society of Delaware; the report of the Nominating Committee; and the acceptance speech of President-Elect Martin G. Begley, M.D.

Doctor Grubbs called upon Roger B. Thomas, Jr., M.D., Speaker of the House of Delegates, and Joseph A. Lieberman III, M.D., to preside during the reports of the Reference Committees.

REPORTS OF THE OFFICERS

REPORT OF THE PRESIDENT

The 1998 MSD year has been successful with members receiving a high level of services, the Society achieving numerous accomplishments, and the Society establishing its future direction. This suc-

cessful year is attributable to the diligent dedicated work of many members, your Trustees, officers, and staff. The Society is positioned to embrace the needs of Delaware physicians and develop new member services as we transition into the twenty-first century. I will highlight several of the year's achievements and activities, but the depth and breadth of our Society's activities is best appreciated by reviewing the entire 1998 annual report.

MSD can claim an outstanding year of achievement in the following areas:

- State legislation and regulation
- Strategic planning
- National AMA Leadership
- Member service subsidiary development
- Communications
- Physicians' Advocate Program
- Staff and facility development

MSD activity in Dover in 1998 was at its highest level in years and achieved passage of significant legislation and adoption of insurance regulation. MSD initiated SB 194, which was signed into law and provides for physician due process with managed care organizations. HB 673, also initiated by MSD, was adopted and adds an MSD-designated physician to the Delaware Workers' Compensation Advisory Group. HB 650, which proposed to lengthen the statute of limitation for medical negligence suits, was defeated, and SB 339, allowing pharmacists to administer injectables and provide finger stick lab testing, was significantly revised by MSD legislative activities. Legislative liaison Phil Corrozi is commended for his outstanding contribution to these successes.

In addition, the Delaware Insurance Commissioner's office has activated a prompt payment regulation by insurance companies to physicians. The regulation was based on model regulations provided by MSD. This successful legislative year has been evaluated by MSD leadership, and plans for a more streamlined and responsive MSD legislative process are underway to guarantee even more future achievements.

President-Elect Martin G. Begley, M.D., has chaired a Strategic Planning Committee that has set the future course of MSD at a retreat attended by 24 Society members. The Society's core purpose — to guide, serve, and support Delaware physicians, promoting the practice and profession of medicine to enhance the health of our communities — was identified, and specific strategic objectives for the Society were established. Our Society road map to the future is clear.

The MSD AMA delegation has had an outstanding year representing

Delaware physicians. Head delegate, Stephen R. Permut, M.D., achieved national recognition and acclaim by chairing the AMA Reference Committee that crafted the AMA House of Delegates' position on Evaluation and Management Coding. The leadership of Carol A. Tavani, M.D., has been recognized by her election to the executive committee of the Organization of State Medical Association Presidents.

MSD's three subsidiaries, providing member services, have all produced a year of achievement and growth. MSDIS has modified and strengthened its relationship with Zutzy, PLI and RTA insurance organizations. The growing relationship has allowed MSDIS to regionalize its insurance product. This solid subsidiary will continue to provide an ever expanding group of insurance services to our members and continues to be a growing and essential financial resource to our Society. President Thomas J. Maxwell, M.D., William H. Duncan, M.D., and the MSDIS Board are commended for another spectacular year of leadership.

MED-NET OF DELAWARE has continued to develop under the leadership of Michael J. Bradley, D.O., and President James H. Wilton. A third independent physician organization has evolved in Lewes and joins existing organizations in Seaford and New Castle County. Infrastructure to support the affiliated physicians organizations has been established with services provided by nationally recognized Meridian Health Care Management. A contract negotiating team consisting of professional negotiators, actuaries, legal counsel, and physicians has been activated, and MED-NET secured its first statewide risk sharing contract for the POs in October.

Credentialing Connection has been awarded a contract with BCBS of

Delaware to provide primary verification services. To date, 150 physician files have been completed and CCI is poised to obtain NCQA certification in the first quarter of 1999. NCQA certification will allow CCI to expand its business. In addition, CCI has completed over 1,100 managed care applications for physician members. The leadership of Anthony R. Cucuzzella, M.D., and extraordinary efforts of Director Lisa Mc Collum have been outstanding.

MSD has also entered into a new joint venture with the Delmarva Foundation for Medical Care by establishing a MSD majority owned corporation to bid on and obtain the Delaware PRO contract. This will allow MSD to remain active in the promotion of quality medical care in our communities.

The MSD communications system has never been better. The broadcast fax system equipment has been upgraded, and members receive rapid and timely communications of significant events and information. The MSD web site has been redesigned and shows increasing levels of access. The *Delaware Medical Journal* has also been redesigned by new editor G. Stephen DeCherney, M.D., and members continue to receive a monthly MSD newsletter.

The Physicians' Advocate Program has grown under new director Anne Allen. Regular meetings continue with insurance companies and our new Medicare carrier. There has been increasing collaboration with our regional state medical societies (MD, DC, VA) with regular meetings dealing with insurance company and Medicare issues. The contract review service provides timely reviews of new provider agreements and amendments. The Medical Business Specialist certificate program graduated its first student, who successfully com-

pleted eight courses in the fundamentals of medical office administration.

MSD has provided increasing levels of administrative support services to our state, specialty, and county medical societies. Through the efforts of staff member Mary LaJudice, MSD now provides support to six medical specialty societies and both Kent and Sussex County Medical Societies. The Young Physicians Section has concluded its first full year of activities under the leadership of Michael Katz, M.D. and has been extremely active at all levels of the Society, the House of Delegates, and at the national level with the AMA.

Finally, MSD has upgraded its facilities, with renovations at the Delaware Academy of Medicine. Further renovations are planned for 1999 to assure space for our growing subsidiaries. The MSD staff has been bolstered with the addition of new accounting personnel.

One cannot end a year's review without recognizing the essential contribution of the MSD staff. The MSD could not function without the efforts of our fine staff under the superb direction of Executive Director Mark A. Meister. Our staff members not only perform well but continually exhibit their personal dedication to the physicians and health of our community.

I have been honored to serve as your President and believe the MSD has never been better prepared to serve our membership and communities in the challenging years ahead. Thank you for your support in meeting the challenges of 1998.

Stephen S. Grubbs, M.D.
President

The report was filed with special commendation to Dr. Grubbs for his excellent year as president of the Medical Society of Delaware.

PRESIDENT-ELECT'S REPORT

This has been a very busy year for the Medical Society of Delaware. The work of the Society has increased in response to the demands created by the rapid changes that continue to occur in health care. This, in turn, made the year busy, challenging and satisfying for your President-Elect.

In the service of the Medical Society of Delaware, I have been involved in many intramural and extramural activities. The **extramural activities** included representing the Society at the following functions:

- Medical Society of New Jersey Annual Meeting: I attended this meeting representing MSD and hosted the president of the Medical Society of New Jersey, Dr. Carl Restivo, and his wife, Lana, at our annual meeting.
- Health insurance company meetings.
- Meeting with the Board of Medical Practice to discuss licensure requirements for physicians who influence the care of patients in Delaware through telemedicine or who act as reviewers for insurance companies.
- Meeting with Governor Carper to discuss legislation that would affect health care for Delawareans including patients rights and due-process for physicians.
- Meetings with members of the state legislature to discuss legislation that would affect patients, physicians and the essential patient-physician relationship.
- Member of MSD's delegation which met with the staffs of Senators Roth and Biden and Congressman Castle.

Intramural activities in which I was involved included regular participation on the Board of Trustees, the Board of Trustees Executive Committee, Board of Directors of MedNet, Budget Committee, Personnel Committee, Nominating Committee, DELPAC, Legislative Strategy Committee and Ad-Hoc Oversight Committee (Chairman).

The most important task that I have been involved with has been the development of a format the Society can use to do regular strategic planning and the development of a strategic plan. To all the changes that have recently occurred in health care, medicine has generally been reactive rather than proactive in its response. Groups and organizations other than physicians have taken the lead and the results have not been in patients' best interest.

As the President-Elect, I have seen one of my essential duties to look to the future needs of MSD and make it more proactive. To do that, we had to develop a vehicle for planning that would take into account the present needs of MSD, the concerns and goals of the members of our society, changes that are occurring in medicine, future needs of MSD and the people of Delaware.

The need for **strategic planning** was presented to the Board of Trustees and a committee was chosen to investigate ways to best do strategic planning.

To initiate this process, research into the processes and interviews of those experienced in planning was performed. These efforts indicated that MSD would be best served if it were to develop a plan to guide its operation for the next two to three years and the plan would best be developed using a retreat format. Such a retreat is a regular exercise in successful corporations and institutions. The Retreat was held on March 6 and 7, 1998, in Rehoboth Beach. Mr. Edward

Lange from the firm of The Touchstone Group, Ltd., was engaged as the facilitator of the retreat. He was chosen for this task because of his extensive experience in strategic planning with for-profit and not-for-profit corporations and institutions. A panel of participants was assembled. Representatives from the MSD Board of Trustees and Long Range Planning Committee were joined by a group of invited participants. The latter members of the panel were chosen in order to assure a good cross section of all the physicians practicing in Delaware. The members of the panel represented the gamut of primary and consultant specialties, physicians both new and established in practice, those in solo, partnership and group practices, international medical graduates, women physicians, the different areas and hospitals of our state, academic and administrative medicine, physicians who were not members of the MSD, etc. Also partaking were MSD staff members. While Mr. Lange warned that groups of more than 15 would probably prove unwieldy, if not outright combative, the panel consisted of 30 members. Contrary to Mr. Lange's expectation, born of his considerable previous experience, the whole panel always worked with an admirably collegial spirit.

The retreat started with a review of the MSD's core ideology and values and adopted a statement

MSD's core purpose:

To guide, serve and support Delaware physicians, promoting the practice and profession of medicine to enhance the health of our communities.

We identified our stakeholders, the major ones being our patients and members and the community-at-large. Then the current status of MSD was evaluated and its strengths and weaknesses identified. The primary strengths recognized are the MSD staff and the

potential power that we have in the number of physicians who are members. Our most serious weaknesses are the small numbers of members who are actively involved in MSD, lack of effective communications with our members and the public and unclear goals for the Society. We identified primary challenges MSD faces: the changes in health care, need for better communications, need for more political action, lack of modernization in our computer systems and our Society's physical plant, hassle factors members face from government and insurance companies, and the need to identify more sources of revenue for the society. We then chose immediate goals for our society:

1. Assist physicians in forming autonomous local multi-specialty networks as vehicles to restore leadership and for contracting and clinical integration.
2. Develop a directory of media contacts for MSD.
3. Institute a weekly FAX bulletin of MSD news and activities.
4. Increase membership in DELPAC by 200.
5. Set up a network that relates to all Delaware physicians, summaries and updates, including alerts, about health related bills.
6. Put 100 percent of MSD publications and communications on electronic data transmission format.
7. Establish a committee to assess physical plant options.
8. Develop and expand consultative contract services to provide timely service to individual practices.
9. Secure one piece of legislation that reduces the hassles in the practice of medicine.

10. Improve capital and revenue for the society.

Finally, we estimated the impact these goals would have on the members and staff of the society and its fiscal resources and a plan was adopted to achieve the goals. A complete copy of the strategic plan was published in the May 1998 *Delaware Medical Journal*.

I am happy to report that all of the goals of the strategic plan have been acted upon. Most have been achieved and I refer you to the report of the Oversight Committee for those details.

The strategic plan has already proved to be a powerful guide that has energized MSD. It reflects the main concerns of the membership of the society and their needs. It has strength but also flexibility. It is a work-in-progress that will be enhanced in future planning sessions and modified as needed. We invite any comment or suggestions that members of the society may have relevant to this ongoing planning. It is the goal of the officers of MSD to serve your best interests.

In closing, I wish to thank the members of the Medical Society of Delaware for the honor of serving as your President-Elect for the past year. I was pleased and benefited to have had the opportunity to serve with our President, Dr. Stephen Grubbs, our Vice-President, Dr. Michael Alexander, and Secretary, Dr. Edward Quinn, all of whom have done outstanding jobs. And none of this would have been possible without the efficiency and dedication of the staff of MSD with Mr. Mark Meister's exceptional insight and organization.

Martin G. Begley, M.D.
President-Elect

The report was filed with commendation to Dr. Begley.

REPORT OF THE VICE PRESIDENT

In addition to serving on the Executive Committee and the Budget and Finance Committee, the Vice President has been involved in serving on the Board of the Credentialing Connection. The Credentialing Connection report will be covered elsewhere in the materials for this meeting.

I was the guest of the Delaware Dental Society meeting this past summer. I was impressed with the level of involvement and commitment they have to their Society.

Just prior to our Annual Meeting in November, I will be attending the Pennsylvania Medical Society Annual Meeting as their guest.

The most important activity of this year has been in observing the grasp of the current President, Stephen Grubbs, of the many issues involved in serving as President of this organization. Unlike some organizations, where the vice president is a ceremonial decoration, Dr. Grubbs has encouraged me to attend and be involved in a number of meetings. This would include the regularly scheduled meetings with DuPont and Aetna/US Healthcare. I have had continued involvement in the Legislative Committee.

It has been a steep learning curve. I have appreciated the many opportunities to observe many of these committees and activities first hand and stand in awe of the amount of time so many of our members contribute.

Michael A. Alexander, M.D.
Vice President

The report was filed.

REPORT OF THE SECRETARY

The Society's Board of Trustees changed its meeting schedule from monthly to quarterly meetings for 1998, alternating between meeting sites in Dover and Wilmington. Executive Committee meetings were held in the months the Board did not meet. All business transacted at meetings of the Society's Board of Trustees and Executive Committee has been recorded in the minutes as presented by the Secretary. The Medical Society's committees and subsidiary organizations have also held numerous meetings throughout the year, and minutes are on file in the office of the Society.

A comparison of the Society's membership in 1998 and 1997 follows.

1998 Membership *

	Kent	NC	Sussex
Dues-Paying	119	818	171
Dues-Exempt	22	208	32
Affiliates	3	105	4
Totals	144	1131	207

* As of 10/30/98. Figures do not include 65 pending applications.

1997 Membership **

	Kent	NC	Sussex
Dues-Paying	112	838	153
Dues-Exempt	22	197	34
Affiliates	3	84	4
Totals	137	1119	191

** As of 11/6/97. Figures did not include 20 pending applications

A complete report of the Proceedings of the 1998 House of Delegates will appear in the January 1999 and February 1999 issues of the *Delaware Medical Journal*. The report will also be on file in the office of the State Medical Society.

Edward F. Quinn III, M.D.
Secretary

The report was filed.

TREASURER'S REPORT

The financial statement accompanying this report reflects the first nine months of activity for the 1998 fiscal year. After nine months of operation, it appears that the fiscal year of 1998 will be very close to initial budget projections without a deficit. The following budget line items are worthy of special note:

REVENUE

1. Membership revenue is within four percent of budget and is considered complete for this year.
2. Services revenue is ahead of budget for the first nine months of the year, which we anticipate to continue for the balance of the year.
3. Revenue for the *Delaware Medical Journal* is off by almost 30 percent as of September 30th. This represents an unanticipated and thus far unexplained down turn in advertising revenue for our journal. While advertising sales for October appear to have recovered to budgeted levels, it is too early to tell whether this negative trend has been reversed.

EXPENSES

1. A non-budgeted expense of \$6,908.00 for the Society's strategic planning retreat was incurred earlier in the year.
2. Legal counsel is running over budget primarily due to the need for legal advice on several important legislative initiatives of the Society this year.
3. The equipment line item is over budget, reflecting Board-authorized upgrades to the Society's computer system during the year.
4. We will end the year slightly over budget in the travel line item. This is due to the implementation of board policy to send the Alternate Delegates and one

representative from the Young Physicians Section to the annual and interim meetings of the AMA.

5. The subscription line item is over budget due to the inclusion of the DMJ copyright fee, seminar registrations for staff development and trade journal subscriptions.

Many thanks and appreciation go to all the staff, especially Mr. Mark Meister for his invaluable help in daily operations. I would also like to thank Mr. Martins Onos, our Director of Finance, for his compilations of the figures and data that were necessary during the year.

Garth A. Koniver, M.D., FACR
Treasurer

The report was filed with accompanying documents (1998 Treasurer's Report as of 9/30/98; Independent Auditors' Report and Medical Society of Delaware and Subsidiary Consolidating Balance Sheet, 12/31/97) and with a commendation to Dr. Koniver for his outstanding job as Treasurer over the last several years.

**BANKING, INVESTMENT AND FUND
ACCOUNT BALANCES AS OF
SEPTEMBER 30, 1998**

CASH

Cash in bank	\$ 4,709.78
Petty cash	\$ 300.00
TOTAL CASH	\$ 5,009.78

SHORT TERM INVESTMENTS

Lockwood Money Market Fund	\$ 3,005.60
TOTAL SHORT TERM INVESTMENTS	\$ 3,005.60

LONG TERM INVESTMENTS

Portfolio	\$ 60,585.18
Building	\$ 225,511.53
Benevolence	\$ 33,658.43
Med Benefits	\$ 16,829.22
DMJ	\$ 16,396.01
TOTAL LONG TERM INVESTMENTS	\$ 352,980.38

TOTAL CASH AND INVESTMENTS	\$ 360,995.76
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1998 TREASURER'S REPORT AS OF SEPTEMBER 30, 1998

REVENUE	Annual Budget	Actual as of 9/30/98	% of Budget
MEMBERSHIP	348,484	333,208	96%
SERVICES	93,642	79,046	84%
INTEREST/DIVIDENDS	195,100	191,796	98%
ADVERTISING	67,140	35,772	53%
SUBSCRIPTIONS	2,400	503	21%
EDUCATIONAL PROGRAMS	55,715	42,375	76%
ANNUAL MEETING	55,000	40,907	74%
FOUNDATION TRANSFER	20,000	20,000	100%
ROSTER	19,040	9,321	49%
MISCELLANEOUS	500	0	0%
TOTAL REVENUE	857,021	752,927	88%

EXPENSES

PERSONNEL	399,706	295,190	74%
MEETINGS	36,933	21,193	57%
STRATEGIC PLAN	0	6,908	-
INSURANCE	6,067	2,290	38%
PRESIDENT'S HONORARIUM	25,000	18,750	75%
MEDICAL DIRECTOR	25,000	18,750	75%
LEGAL COUNSEL	15,000	14,248	95%
ACCOUNTING/AUDIT	7,000	0	0%
LEGISLATIVE SPECIALIST	38,000	26,687	70%
CONSULTANT	0	7,044	-
OFFICE SPACE	30,086	15,309	51%
OFFICE SUPPLIES	6,700	6,460	96%
TELEPHONE	8,000	7,243	91%
POSTAGE	27,697	13,953	50%
PRINTING	68,849	34,586	50%
PHOTOCOPY	5,821	2,744	47%
EQUIPMENT	9,275	15,284	165%
ACCREDITED CME	16,390	7,006	43%
WORKSHOPS/EDUCATION	31,555	11,296	36%
TRAVEL	29,927	27,914	93%
NEWSLETTER	4,889	3,935	80%
DUES/CONTRIBUTIONS	7,306	4,600	63%
SUBSCRIPTIONS	1,000	3,553	355%
ALLIANCE	4,055	3,750	92%
DMJ DUES EXEMPT	3,150	0	0%
ROSTER	20,090	3,562	18%
BENEVOLENT FUND	1,105	0	0%
MISCELLANEOUS	1,000	1,506	151%
TOTAL EXPENSES	829,601	573,762	69%
SURPLUS (DEFICIT)	27,420	179,165	-

1: Includes 1998 dues of \$88,052 deposited in 1997

2: Includes \$5,239 incurred in 1997 for the AMA Interim meeting



HAGGERTY & HAGGERTY, P.A.

CERTIFIED PUBLIC ACCOUNTANTS
& MANAGEMENT CONSULTANTS

James R. Zdimal, CPA†
Vincent S. Barbone, CPA, CFE*†

American Institute of CPA
Pennsylvania Institute of CPA*
Delaware Society of CPA†
Private Companies Practice Section

Independent Auditors' Report

Board of Directors
Medical Society of Delaware & Subsidiaries
Wilmington, Delaware

We have audited the accompanying statement of financial position of the Medical Society of Delaware & Subsidiaries (a not-for-profit organization) as of December 31, 1997, and the related consolidated statement of activities, and cash flows for the year then ended. These financial statements are the responsibility of the Society's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medical Society of Delaware & Subsidiaries as of December 31, 1997, and the changes in net assets, and its cash flows for the year then ended in conformity with generally accepted accounting principles.

Our audit has been made primarily for the purpose of forming the opinion stated in the preceding paragraph. The additional information contained in this report is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated, in all material respects, in relation to the financial statements taken as a whole.

Haggerty Haggerty
Certified Public Accountants

May 8, 1998
Wilmington, Delaware

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MEDICAL SOCIETY OF DELAWARE & SUBSIDIARIES
CONSOLIDATING BALANCE SHEET
 December 31, 1997

	Medical Society of Delaware (MSD)					Subsidiaries			
	Assets	Current Funds	De Medical Journal	Restricted	Custodian Fund	MSD Insurance Services, Inc.	Credentiaing Connection, Inc.	Medical Network Management, Inc.	Elimination Entries
CURRENT ASSETS									
Cash and equivalents	\$ 160,715	\$ 19,238	\$...	\$...	\$ 661	\$ 135,391	\$ 4,288	\$ 51,849	\$...
Receivables:									
Commissions	180,000	...	...	...	...	121,912	...	...	(180,000)
Dividends	403,729	...	8,319	...	...	36,511	3,105	...	(412,048)
Affiliates	...	18,511	...	...	...	4,500	...	...	...
Other	1,636	...	...	...	...	...	...	...	...
Prepayments	123,009	...	351,338	...	...	...	...	...	...
Security deposit	43,100	...	...	...	...	...	...	...	...
Investments	912,182	37,749	359,657	...	661	298,314	7,393	51,849	(43,100)
Investment in subsidiaries	...	...	...	...	...	...	...	...	(635,148)
Total current assets	\$ 1,032,664	\$ 19,238	\$ 359,657	\$...	\$ 661	\$ 298,314	\$ 7,393	\$ 51,849	\$ 372,142
PROPERTY AND EQUIPMENT AT COST									
Leasehold improvements	21,354	28,015	...	...	...	50,962	28,897	5,724	...
Furniture, fixtures and equipment	76,078	28,015	...	...	...	50,962	28,897	5,724	...
Less: Accumulated depreciation	97,432	28,015	...	...	...	40,124	6,856	1,431	...
Net property and equipment	66,206	27,291	...	...	...	10,838	22,041	4,293	...
OTHER ASSETS									
Organization cost, net of amortization of \$41	...	...	...	...	...	...	115	78,204	...
Deferred taxes	...	...	...	...	...	...	65,518	78,204	...
Total assets	\$ 943,415	\$ 38,473	\$ 359,657	\$...	\$ 661	\$ 309,152	\$ 95,067	\$ 134,346	\$ (635,148)
LIABILITIES AND FUND EQUITY									
CURRENT LIABILITIES									
Dues payable	\$ 125,995	\$ 16,105	\$...	\$...	\$...	\$ 10,443	\$ 161,277	\$ 215,904	\$ (412,048)
Due to affiliated agencies	8,319	...	...	...	...	14,972	...	...	...
Accrued expenses	18,729	...	...	...	...	180,000	...	...	(180,000)
Dividends payable	...	...	...	...	...	...	...	...	...
Payables - other	10,184	...	65,764	...	...	22,931	...	...	...
Corporate income taxes payable	7,594	...	...	...	...	...	...	...	...
Amounts held for physician emeritus	36,451	...	...	...	661	...	...	...	...
Compensated absences payable	207,272	16,105	65,764	...	661	228,346	161,277	215,904	(592,048)
Total current liabilities	\$ 86,996	\$ 1,160	\$ 116	\$...	\$ 661	\$ 228,346	\$ 161,277	\$ 215,904	\$ (592,048)
DEFERRED REVENUE									
Total liabilities and deferrals	\$ 294,268	\$ 17,265	\$ 65,880	\$...	\$ 661	\$ 228,346	\$ 161,277	\$ 215,904	\$ (592,048)
FUND EQUITY									
Fund balances	649,147	21,208	293,777	...	...	100	13,000	30,000	(43,100)
Common stock	...	...	...	...	...	80,706	(79,210)	(111,358)	(110,062)
Retained earnings (deficit)	649,147	21,208	293,777	...	...	80,806	(66,210)	(81,358)	(43,100)
Total fund equity	\$ 943,415	\$ 38,473	\$ 359,657	\$...	\$ 661	\$ 309,152	\$ 95,067	\$ 134,346	\$ (635,148)
TOTAL LIABILITIES AND FUND EQUITY									
	\$ 943,415	\$ 38,473	\$ 359,657	\$...	\$ 661	\$ 309,152	\$ 95,067	\$ 134,346	\$ (635,148)
									\$ 1,245,623

SOCIETY REPORTS

KENT COUNTY MEDICAL SOCIETY

The Kent County Medical Society continues to meet quarterly. Our October 22, 1997, meeting was held at the Maple Dale Country Club. In addition to our usual business, we heard a presentation from Dr. Michael Riisager and Susan Williams of Trail Blazer Health Enterprises representing their company, which became the new Medicare carrier for Delaware in February 1998.

The next quarterly meeting was March 4, 1998, at the Dover Sheraton. At that meeting we heard an update on Credentialing Connection by Lisa Mc Collum.

Our May 13, 1998, meeting was held at the Sheraton Inn. Dr. Martin Begley discussed the Strategic Planning Initiative that was formulated in March 1998. Dr. Stephen Grubbs also updated the membership on enacting the strategic plan.

Our fourth quarterly meeting held in August 1998 at Sambo's. As always, this is our attendance record for the year. Dr. Zaragoza reported a very healthy treasury balance at \$23,620.51 prior to disbursements for that evening's food. The new delegates from Kent County were likewise introduced and approved by the membership. They include Lee M. Dennis, M.D.; Brett Elliott, M.D.; Robert Heckman, M.D.; Wellford Inge, M.D.; Norman Jones, M.D.; Michael Mattern, M.D.; Venerando Maximo, M.D.; Julia Pillsbury, D.O.; William Rosenfeld, M.D.; Robert Varipapa, M.D.; Joseph Andrews, M.D.; Stephen Vernon, D.O.; Gertrude Findley-Christian, M.D.; and Joseph Rubacky III, D.O. Alternate delegates include Brian M. Benson, Jr., M.D.; Richard DuShuttle, M.D.; Harjinder Grewal, M.D.; William

Kaplan, M.D.; Robert Moyer, M.D.; Andrew Willet, M.D.; Calvin Wilson II, M.D.; Gregg Sylvester, M.D.; and Basilio Bautista, M.D.

Officers who are entering the second year of their two year term are Brian J. Walsh, D.O. — President; Gertrude Findley-Christian, M.D. — Vice President and President-Elect; Michael Zaragoza, M.D. — Treasurer; and Sidney Barnes, M.D. — Secretary. Trustees from Kent County as approved by the membership include Brian Walsh, D.O.; Sidney Barnes, M.D.; and Michael Zaragoza, M.D.

We continue to welcome many new physicians to our community and many new members to the Kent County Medical Society. We look forward to another growth year in 1998. We wish to thank Dr. Stephen Grubbs for his service as the President of the Medical Society of Delaware and wish Dr. Martin Begley of the Kent County Medical Society well in his upcoming year as president of the Medical Society of Delaware.

Brian J. Walsh, D.O.
President

The report was filed.

NEW CASTLE COUNTY MEDICAL SOCIETY

The New Castle County Medical Society held one membership meeting this past year. Due to declining attendance, we have been experimenting with the number, time and format for membership meetings. The Board of Directors and committees met on a regular basis throughout the year. In addition, we continue to sponsor the breakfast speaker for the Medical Society of Delaware's Annual House of Delegates Meeting.

At the Society's Annual Meeting in March, we sponsored a discus-

sion about the "third party messenger system." The guest speakers were Edward Hirshfeld, Associate General Counsel from the AMA, and Jack Seddon, Executive Director of the Federation of Physicians and Dentists. Mr. Hirshfeld said physicians have lost their autonomy and are constantly subjected to delayed payments, unfair contracts with gag clauses, given no opportunities to negotiate fee schedules and told what is medically necessary. The third party messenger system is legal; however, physicians need to be aware of antitrust law implications. The third party messenger may not negotiate the contract for physicians. The messenger system primarily serves as a conduit of information for physicians. Mr. Hirshfeld urged physicians to gather some leverage against these unfair practices. A good place to start is to collect evidence, confront managed care plans, build public support, and go to the press. Then, take the information and support to the legislature. He also urged physicians to work together through organized medicine to help correct these problems.

Mr. Seddon presented a brief background on the Federation of Physicians and Dentists. The Federation is a nonprofit organization representing thousands of salaried and fee-for-service physicians in a variety of private and public sector settings and in all fields of medicine. The Federation provides expert counsel and representation for physicians negotiating agreements with managed care companies. They also offer a confidential service which provides reports on insurance companies and economic surveys. They can represent members in collective bargaining and other labor-related matters. The basic philosophy of the Federation is that medical decisions should be made by physicians. Mr. Seddon said too often today, health care is compromised by corporate administrators and patients end

up suffering. He also addressed questions about the local conflict between Blue Cross and area orthopaedic surgeons.

I would like to take this opportunity to thank committee chairmen and the Board of Directors for their work during the past year. I would also like to express my appreciation to the members and staff for their help and support.

Léo W. Rasis, M.D.
President

The report was filed.

SUSSEX COUNTY MEDICAL SOCIETY

Membership growth in past year approximately doubled. Our plan for revised Bylaws is in progress.

University of Delaware professor presented a complete review of the Pfiesteria problem including environmental and health concerns.

A Strategic Plan presentation given by Drs. Begley and Grubbs was informative and motivating.

A presentation by a local chiropractor provided insight into their perspective of health care.

Richard H. Sherman, M.D.
President

The report was filed.

OTHER REPORTS

REPRESENTATIVE OF THE DELAWARE ACADEMY OF MEDICINE

Over the past year, The Academy underwent a major renovation project to update its bathroom facilities. The old bathrooms were

demolished and a new enlarged women's bathroom was built in that space. A new men's bathroom was constructed in what was the old coat room. In addition, we converted the old projection room into office space for the Medical Society of Delaware and installed a complete new sound system in the Auditorium. Further renovations will continue throughout the coming year.

As the cornerstone of The Academy, the Lewis B. Flinn Library continues to provide a full range of Library services to our membership. Primary services include reference, computer literature searching, and interlibrary loan. During the past year, 10,467 interlibrary loan requests and 642 computer literature searches were completed by our Library staff. The Library's Circuit Riding Medical Librarian Program recently expanded into Philadelphia. The Program now provides Library services on a contractual basis to Delaware Psychiatric Center, Nanticoke Hospital, St. Francis Hospital and Friends Psychiatric Hospital.

In an effort to promote health education in the community, our Consumer Health Library staff attends health fairs and answers requests statewide. Last year, staff filled 2,277 interlibrary loan requests and conducted 935 searches. In conjunction with the Consumer Health Library, TEL-MED, our automated telephone system, serves as a popular information resource for the public with over 430 health related recorded messages and still averages over 10,000 calls per month. The Academy provides TEL-MED as a public service statewide. Visitors to our Website, www.delamed.org, continue to solicit and receive health information plus important links to other directories. The Library also received a \$45,000 grant from the National

Library of Medicine to help educate and train individuals about AIDS through the HIV Consortium.

Throughout the year, the Library's History Committee solicited donations of memorabilia and artifacts for our Historical Collection. The Committee finished a major project of installing new lighting in the lobby display cases this past year. They also identified and catalogued numerous items in the collection in an effort to help preserve the history of medicine and dentistry in Delaware.

The Academy's Student Financial Aid Program provides assistance to Delawareans pursuing careers in medicine, dentistry or allied health fields through a revolving loan fund. During 1998, 27 students were awarded \$83,500 in loans.

The monthly calendar of **Medical-Dental Meetings in Delaware** continues to be compiled and distributed by The Academy. It serves as the only comprehensive listing of continuing education conferences for physicians and dentists in the state. In addition, the monthly calendar is now available under *Calendar of Events* on our Website at www.delamed.org.

The Academy's Auditorium and Conference Center were used for numerous medical and dental meetings last year. The Medical Society of Delaware, New Castle County Medical Society and the Delaware State Dental Society were the primary users of the meeting facilities. However, the facilities were also utilized by other business, civic and nonprofit organizations.

The Executive Committee manages the operation and programs of The Academy during the course of the year. We would like to take this opportunity to thank all those

individuals and organizations that supported our programs and services during the past year.

Leslie W. Whitney, M.D.
Representative

The report was filed.

EXECUTIVE DIRECTOR'S REPORT

One year ago, I reported on the dynamic change your Society is experiencing in its pursuit of advocacy and representation on behalf of the medical profession in our state. With this change has come unprecedented opportunity for better serving our membership. Subsidiary corporations have been formed to serve as vehicles for dedicating our financial, staff and member volunteer resources in specialized areas of support and service to Delaware physicians. This year has witnessed significant progress in our subsidiary operations, effectively positioning the Society for the attainment of greater levels of service in the future.

Great strides have been made in the past few years in developing innovative programs and services for Delaware physicians. With the third lowest dues structure in the nation, the Society has had to look to outside revenue to sustain these efforts. Fortunately, we have needed to look no further than our own insurance subsidiary, MSDIS, which has provided funding for so many of these projects in the past. As we enter our fifth year of our joint venture arrangement with Zutz/PLI and RTA (HealthSelect), it is no coincidence that MSDIS also has recorded its fifth record dividend. A significant change this past year, which bodes well for the ongoing vibrancy of the MSDIS enterprise, is

the combining forces of Zutz/PLI with HealthSelect in a formal, joint marketing agreement. HealthSelect has been a true success story for MSDIS and the teaming up of our health insurance program with the very capable and substantial Zutz-PLI organization will allow the regionalization of the HealthSelect program with resulting revenue potential for MSDIS in the sale of insurance products to professional groups outside Delaware.

1998 was a pivotal year for the Society's subsidiary, Med-Net of Delaware, as well. Med-Net representation continued to broaden this year with the successful development of a physician organization (PO) for Eastern Sussex County. Med-Net now represents over 420 physicians covering two of Delaware's three counties. Since each PO has single signature authority for its stockholder participating physicians, a payor is able to secure the services of three complete multi-specialty networks with three signatures. We are optimistic about the prospect of the Kent County physicians deciding to form a PO in the coming year. Should this happen, Med-Net potentially could represent what we believe to be the first statewide alliance of independent POs in the country. Another major development for Med-Net this year was the alignment between Med-Net and Meridian Health Care Management, which solidified Med-Net's infrastructure necessary to supply the medical management and informational needs of the POs. Meridian's proven track record and expertise in these areas of managed care risk contracting enables Med-Net to stay on the leading edge of physician-directed managed care product design and implementation. Most significantly, Med-Net has announced that each of the three POs it represents have

signed Letters of Agreement for their first risk-sharing contracts.

The Society's credentialing subsidiary, Credentialing Connection, Inc., made a major breakthrough this year with the signing of a contract with Blue Cross Blue Shield of Delaware to primarily verify 150 credentialing files in preparation for qualifying for NCQA certification. Without certification, most managed care companies have been reluctant to contract with CCI; however, CCI could not become eligible for NCQA certification until it had completed 150 verifications. A classic "catch 22." BCBS's demonstration of good faith in providing CCI the necessary files to meet this requirement enables CCI to undergo an NCQA audit in January of next year. If certified, plans call for CCI to assume all primary source verifications for BCBS. CCI's relationship with BCBS will bring us significantly closer to our goal of serving as a true centralized resource for credentials verification in Delaware. In addition, CCI's application Completion Service continues to grow. Since its inception in 1996, the service has enrolled more than 300 physicians and has completed over 1100 applications.

As I prepare this report, another subsidiary corporation for the Society is under development. Following the theme of "change yields opportunity," the Society was approached earlier this year by the Delmarva Foundation for Medical Care, the PRO for Maryland and Washington DC. With the contract for the PRO Sixth Scope of Work undergoing a competitive bid process for Delaware, Delmarva proposed a joint venture with the Society to form a subsidiary corporation to become the in-state PRO for Delaware. A lengthy process was undertaken by a special ad hoc com-

mittee appointed by Dr. Grubbs with the recommendation to proceed with the Delmarva proposal. Integral involvement in the PRO program was viewed by the Board of Trustees as an important opportunity to further the Society's role of representation and advocacy for the medical profession in our state.

It is a privilege to serve as your executive director and to assist the leadership of this organization at such a dynamic and challenging time in the long and rich history of the Medical Society of Delaware. As always, I am indebted to the fine work and dedication of my fellow staff members and appreciate all they do to keep the day-to-day activities running smoothly and effectively. Most of all I wish to express my admiration for the members of this Society; their selfless commitment to the health of our citizens and dedication to the ideals of professionalism. Thank you for the opportunity to serve.

Mark A. Meister, Sr.
Executive Director

The report was filed.

REPORTS OF ELECTED COMMITTEES

REPORT OF THE AMA DELEGATION

The Delaware Delegation to the AMA continues to be very active with four delegates, four alternate delegates, a young physicians' section delegate, and a residents' physician section delegate. This ten-person delegation is very visible at the annual and interim meetings, and Delaware physicians are receiving greater recognition at the national level. The Delaware AMA Delegation has begun meeting regularly with the AMA Delegation

from the District of Columbia. This has allowed us to pool our ideas and influence. Our delegation continues to be active in the Southeastern State Delegation.

Key issues that the AMA has addressed this year have been patient protection legislation, relaxation of HCFA regulatory guidelines (particularly the E&M codes), and a variety of policies to attempt to reduce the "hassle factor" by reducing the amount of bureaucratic paper work necessary to practice medicine.

The AMA continues to be a vital resource to the physicians of Delaware. By being the largest group of organized physicians, the AMA provides a unified voice for medicine to the public and to government. Furthermore, the resources within the legal and ethics departments of the AMA are invaluable to the Medical Society of Delaware as we deal with these issues within our State.

Stephen R. Permut, M.D., J.D.
Senior Delegate, AMA

The report was filed.

BUDGET AND FINANCE COMMITTEE

The Budget and Finance Committee met six times this year. Three meetings were with our financial adviser, Dace Blaskovitz, and his associates from Lockwood Financial Services Inc. initially. As our investment adviser was moving to a new company with slightly lower fee schedule and a similar concept to our prior investment strategy, it was decided by the committee to make this transition as well. The committee decided to reevaluate this association after the first year of experience, which will be done in 1999 to evaluate performance and any possible change in course of the Society's investments. As of

September 18, 1998, the investment fund had decreased 15.27 percent to a value of \$406,948. In view of the changing markets, this was felt reasonable in today's climate, and the committee indicated its desire to stay fully invested at this time.

The Budget and Finance Committee met three times this year to discuss the 1999 budget. At the initial meeting of July 30, 1998, to discuss the revenue side of the budget, it was noted that membership had increased 10 percent this year. However the advertising revenue of the journal was down by 28 percent. Lengthy discussion as to the sources of income for our Society were held and there was note that we are the fourth lowest dues state society in the nation and that only 42 percent of our overall revenue budget is attributable to membership dues. This is the second lowest ratio in the country.

There was also a lengthy discussion concerning funds needed for our two new subsidiaries, Credentialing Connection, Inc. and MED-NET. The funds needed to continue these two companies are projected to exceed what the Board has approved by approximately \$71,000. It was the committee's recommendation to the Board that a dues increase of \$50 be budgeted for 1999 to replace funds in the investment account. It was also recommended to ask MSDIS for a final assessment of their 1999 dividend in hopes that it could be increased by an additional \$20,000.

On September 9, 1998, the Budget Committee reviewed the entire budget including revenue and expense projections. It was learned that due to successful negotiations with PHICO, the administrative endorsement fee for 1999 would be increased \$10,000 to a total of \$60,000. It was learned that *Del-*

ware *Medical Journal* revenues would probably not increase substantially.

On the expense side of the 1999 budget, a 16 percent increase in personnel is attributable to three factors:

1. The hiring of a new position in the accounting department, which was approved by the Board.
2. Salary upgrades for four staff positions to maintain a competitive salary in the local labor market and,
3. An anticipated cost of living increase of three percent for all employees.

It was noted that because of the computer upgrade done in 1998, some of the projected expenses for 1999 may not be necessary and this item can be decreased.

As a projected deficit of almost \$32,000 was forecast for 1999, it was the committee's opinion that a dues increase was necessary to be fiscally sound. This is in addition to the \$50 increase to begin to replace the Society's reserve funds. In addition, various ways to decrease the projected deficit were discussed.

There was considerable discussion about the Society's cash flow requirements. In order to sustain the operations of the subsidiaries, Credentialing Connections, Inc. and MED-NET, an additional \$225,000 will be necessary for 1998. As there were insufficient funds in the reserve fund to allow these subsidiaries to be maintained and keep our fund level at \$250,000,

which was the Board decision earlier in the year, various options were discussed including:

1. A commercial bridge loan.
2. Revised board policy to use the 1998 MSDIS dividend in 1998.
3. Request payment from MED-NET as is possible and,
4. Establish a line of credit from MSDIS as legally possible

It was felt that MED-NET could repay \$25,000 immediately which would be helpful and the committee preferred a line of credit from MSDIS rather than a commercial source if this was possible.

These recommendations as well as the 1999 budget were discussed and accepted at the October 19, 1998, Board meeting. It was also decided at that meeting that a \$50 assessment for 1999 should be authorized to replace funds in the reserve as well as a \$20 dues increase. The \$31,877 deficit was reduced to \$10,912 by eliminating

- Strategic planning meeting
- New computer parts
- Legislative affairs dinner.

This was a difficult year for the Society's financial picture. 1999 should be an important year for our two new subsidiaries – Credentialing Connection, Inc. and MED-NET. Hopefully these two companies will become self-sustaining or profitable and additional funds from the membership will not be necessary. However, if this is not the case, then we will need to revisit this issue. It should be noted that even with our dues increase of \$20, we still remain at one of the lowest dues levels of state medical societies in the country.

I would like to offer my special thanks to Executive Director, Mark Meister,

and the staff for coming to grips with these most difficult issues and for his great knowledge and expertise in all the areas that pertain to the dealings of the Budget and Finance Committee. I would also like to give special thanks to the entire committee for their participation and invaluable contributions to the important matters at hand.

Garth A. Koniver, M.D., F.A.C.R.
Chair

The report was adopted with approval of a \$50 one-time assessment for active and associate members to replenish the Society's reserve fund and approval of a \$20 increase in the Society's annual dues. Please see pages 36-37 for the 1998 and 1999 All Programs Budget Comparisons and the 1999 Budget.

MEDICAL SOCIETY OF DELAWARE
1999 BUDGET

	1999 BUDGET ALL PROGRAMS	1998 BUDGET ALL PROGRAMS	% CHG.
REVENUE			
MEMBERSHIP	\$385,305	\$348,484	11%
SERVICES	\$109,193	\$93,642	17%
INTEREST/DIVIDENDS	\$226,463	\$195,100	16%
ADVERTISING	\$49,360	\$67,140	-26%
SUBSCRIPTIONS/PUBLICATIONS	\$2,335	\$2,400	-3%
EDUCATIONAL PROGRAMS	\$60,299	\$55,715	8%
ANNUAL MEETING	\$56,136	\$55,000	2%
FOUNDATION TRANSFER	\$20,000	\$20,000	0%
ROSTER	\$13,880	\$19,040	-27%
MISCELLANEOUS	\$500	\$500	0%
TOTAL REVENUE	\$923,471	\$857,021	8%
EXPENSES			
PERSONNEL	\$465,562	\$399,706	16%
MEETINGS	\$33,108	\$36,933	-10%
INSURANCE	\$6,310	\$6,067	4%
PRESIDENT'S HONORARIUM	\$25,000	\$25,000	0%
MEDICAL DIRECTOR	\$25,000	\$25,000	0%
LEGAL COUNSEL	\$14,415	\$15,000	-4%
ACCOUNTING/AUDIT	\$7,000	\$7,000	0%
LEGISLATIVE SPECIALIST	\$39,779	\$38,000	5%
OFFICE SPACE	\$34,720	\$30,086	15%
OFFICE SUPPLIES	\$11,892	\$6,700	77%
TELEPHONE	\$8,426	\$8,000	5%
POSTAGE	\$29,727	\$27,697	7%
PRINTING	\$72,524	\$68,849	5%
PHOTOCOPY	\$8,325	\$5,821	43%
EQUIPMENT	\$12,735	\$9,275	37%
ACCREDITED CME	\$9,900	\$16,390	-40%
WORKSHOPS/EDUCATION	\$43,481	\$31,555	38%
TRAVEL	\$48,587	\$29,927	62%
NEWSLETTER	\$4,190	\$4,889	-14%
DUES/CONTRIBUTIONS	\$7,317	\$7,306	0%
SUBSCRIPTIONS/PUBLICATIONS	\$2,497	\$1,000	150%
ALLIANCE	\$4,055	\$4,055	0%
DMJ DUES EXEMPT	\$2,590	\$3,150	-18%
ROSTER	\$1,000	\$20,090	-95%
BENEVOLENCE FUND	\$1,240	\$1,105	12%
MISCELLANEOUS	\$1,000	\$1,000	0%
TOTAL EXPENSES	\$920,380	\$829,601	11%
SURPLUS (DEFICIT)	\$3,091	\$27,420	-

MEDICAL SOCIETY OF DELAWARE
1999 BUDGET

	ADMINISTRATION	PHYSICIANS' ADVOCATE	YOUNG PHYS SECTM	COMPONENT SOCIETIES	DE. MED JOURNAL	PUBLIC REL & LEG AFFAIRS	PHYSICIANS' HEALTH	CME	ANNUAL MEETING	1999 BUDGET ALL PROGRAMS
REVENUE										
MEMBERSHIP	\$370,315	\$0	\$0	\$0	\$14,990	\$0		\$0	\$0	\$385,305
SERVICES	74,977	26,550	0	7,656	0	0		0	0	\$109,193
INTEREST/DIVIDENDS	226,463	0	0	0	0	0		0	0	\$226,463
ADVERTISING	0	0	0	0	49,360	0		0	0	\$49,360
SUBSCRIPTIONS/PUBLICATIONS	0	0	0	0	2,335	0		0	0	\$2,335
EDUCATIONAL PROGRAMS	0	14,500	1,000	0	0	0		44,799	0	\$60,299
ANNUAL MEETING	0	0	0	0	0	0		0	56,136	\$56,136
FOUNDATION TRANSFER	0	0	0	0	0	0		0	0	\$20,000
ROSTER	13,880	0	0	0	0	0		0	0	\$13,880
MISCELLANEOUS	0	0	0	0	0	500		0	0	\$500
TOTAL REVENUE	\$685,635	\$41,050	\$1,000	\$7,666	\$66,685	\$500	\$20,000	\$44,799	\$56,136	\$923,471
EXPENSES										
PERSONNEL	\$303,828	\$85,008	\$1,781	\$3,206	\$22,838	\$0		\$48,902	\$0	\$465,562
MEETINGS	22,000	1,300	1,106	0	200	1,082	1,120	600	5,700	\$33,108
INSURANCE	6,310	0	0	0	0	0	0	0	0	\$6,310
PRESIDENT'S HONORARIUM	25,000	0	0	0	0	0	0	0	0	\$25,000
MEDICAL DIRECTOR	0	0	0	0	0	0	0	0	0	\$25,000
LEGAL COUNSEL	9,415	5,000	0	0	0	0	0	0	0	\$14,415
ACCOUNTING/AUDIT	7,000	0	0	0	0	0	0	0	0	\$7,000
LEGISLATIVE SPECIALIST	0	0	0	0	0	39,779	0	0	0	\$39,779
OFFICE SPACE	34,720	0	0	0	0	0	0	0	0	\$34,720
OFFICE SUPPLIES	8,942	1,100	612	0	500	0	0	300	438	\$11,892
TELEPHONE	6,746	0	1,680	0	0	0	0	0	0	\$8,426
POSTAGE	21,591	0	800	1,936	4,200	0	0	1,200	0	\$29,727
PRINTING	4,000	4,525	0	0	56,000	0	0	1,000	6,999	\$72,524
PHOTOCOPY	5,918	0	404	724	150	0	0	600	529	\$8,325
EQUIPMENT	12,735	0	0	0	0	0	0	0	0	\$12,735
ACCREDITED CME	0	0	0	0	0	0	0	9,900	0	\$9,900
WORKSHOPS/EDUCATION	0	7,325	0	0	0	0	0	0	36,156	\$43,481
TRAVEL	42,074	729	3,084	0	0	0	1,000	1,700	0	\$48,587
NEWSLETTER	4,190	0	0	0	0	0	0	0	0	\$4,190
DUES/CONTRIBUTIONS	6,132	0	0	0	0	0	0	1,185	0	\$7,317
SUBSCRIPTIONS/PUBLICATIONS	1,672	825	0	0	0	0	0	0	0	\$2,497
ALLIANCE	3,500	0	0	0	0	0	0	0	0	\$4,055
OMJ DUES EXEMPT	2,590	0	0	0	0	0	0	0	0	\$2,590
ROSTER	1,000	0	0	0	0	0	0	0	0	\$1,000
BENEVOLENCE FUND	1,240	0	0	0	0	0	0	0	0	\$1,240
MISCELLANEOUS	1,000	0	0	0	0	0	0	0	0	\$1,000
TOTAL EXPENSES	\$531,603	\$105,812	\$9,467	\$5,866	\$83,888	\$40,861	\$27,120	\$65,387	\$50,377	\$920,380
SURPLUS (DEFICIT)	\$154,032	(\$64,762)	(\$8,467)	\$1,800	(\$17,203)	(\$40,361)	(\$7,120)	(\$20,588)	\$5,759	\$3,091

COMMITTEE ON ETHICS

The Committee on Ethics completed its present cycle having held three meetings in 1997-98.

The first meeting was held on December 3, 1997, when issues related to legislation pertaining to genetics were discussed as a result of House Bill 152 being presented in Dover. This bill would have prohibited obtaining or disclosing genetic information without an individual's informed consent. The comments from the committee included support for a patient's right against disclosure of genetic information and the recommendation that the Medical Society of Delaware adopt a "hard line" on the use of genetic information.

The next meeting was held on March 4, 1998, when updating the Medical Society of Delaware policy on "determination of brain death" was discussed. Also, members of the Committee who attended the Conference of the American Society of Bioethics gave their reports.

Our last meeting was held on June 3, with a follow-up on updating the "determination of brain death" policy, which, because of its complexity, was tabled until more information and input from the specialties involved can be gathered.

Maurice Liebesman, M.D.
Chair

The report was filed with a recommendation for an article in the *Delaware Medical Journal* on the confidentiality of medical reports with specific mention of mental health, substance abuse, and genetic testing issues.

JUDICIAL COUNCIL

During the past year the Judicial Council was called upon to review four requests for dues exemption and one request for reduced dues. All requests were granted.

No other issues have been referred to the Judicial Council in the last year.

Edgar R. Miller, Jr., M.D.
Chair

The report was filed.

REPORTS OF STANDING COMMITTEES

BYLAWS COMMITTEE

The Bylaws Committee has no proposed Bylaws amendments at this time.

The committee is aware that Resolution 98-1, AMA Unification, will be considered by the House of Delegates. In the event this resolution should fail to be adopted, the committee has a mechanism in place to offer a Bylaws amendment to remove the requirement for unified membership.

Dene T. Walters, M.D.
Chair

The report was filed.

LONG RANGE PLANNING COMMITTEE

The Long Range Planning Committee has not met during the past year and there is therefore no report.

Anthony L. Cucuzzella, M.D.
Chair

The report was filed. The Reference Committee's sentiment that there should be consideration of dissolving this committee since it has not been meeting was referred to the Bylaws Committee.

MEDICAL LIABILITY INSURANCE COMMITTEE

The Medical Liability Insurance Committee held its meeting this year on September 23, 1998. Representatives from the Board of Directors of Medical Society of Delaware Insurance Services, Inc., and Mr. Larry Zutz from Zutz/PLI were also present.

The meeting began with a presentation from Mr. Patrick Amice of PHICO. Mr. Amice briefly outlined recent changes that have taken place at PHICO which have strengthened them as a company. There has been positive growth in premiums written, and they continue to show strong financial strength. Along with this, Mr. Amice told us that PHICO continues to be rated as A- by AM Best, but stated that the most recent review should have resulted in an A rating. However, this did not occur because the reviewers were concerned about PHICO's recent rapid diversification.

Other representatives from PHICO discussed related issues. Ms. Stephanie Bush commented on loss control management and noted that PHICO now insures over 600 physicians in Delaware. Mr. Craig Cooper of the Actuarial Department reviewed the various components of premium rate development. He told us that while an increase of 7 percent was justified, PHICO has decided not to file for a rate increase for 1998. In part, this decision was based on the long-term relationship that PHICO has with the Medical Society of Delaware.

In their concluding remarks, PHICO anticipated that there will be a dividend for PHICO insureds for 1998. The amount, which will probably be smaller than last year's, has not been determined but will be decided within the next several weeks.

Following the PHICO presentation, the Medical Liability Insurance Committee heard the Annual Report from MSDIS, presented by Dr. William Duncan. It was noted that a record dividend was recorded and that various other business ventures are being pursued. One of these was the restructuring of the Zutz/PLI/RTA agreements. Dr. Duncan also reported that MSDIS will be expanding its product line to include pension plans through Nicholas Applegate and Wealth Advisors.

Mr. Larry Zutz commented on the financial strength of MSD/Zutz/RTA. He noted that before the joint venture, gross revenue was approximately \$200,000, and today is reaching \$800,000.

This concluded the committee's meeting.

In another area, the committee is pleased to report that it was able to help one physician secure insurance with PHICO when it appeared that the physician was going to be dropped as an insured.

In conclusion, the committee would like to thank Mr. Mark Meister for the work he has done on behalf of this committee.

Richard N. Hindin, M.D.
Chair

The report was filed.

MEDICAL REVIEW COMMITTEE

Again this year there were no requests during the past year for review and resolution of differences in regard to professional fee services by the Medical Review Committee. This is largely due to the considerable changes in the medical environment and the effects that managed care has had on physician fees. The Medical Review Committee chair, however, remains active and meets with other mem-

bers of the Society and regularly scheduled meetings with Blue Cross Blue Shield of Delaware and other major insurance carriers in the State of Delaware.

It is the chair's intention to continue to represent the Society at these meetings, but the Medical Review Committee itself need meet only on specific request.

Anthony L. Cucuzzella, M.D.
Chair

The report was filed. The Reference Committee's sentiment that there should be consideration of dissolving this committee since it has not been meeting was referred to the Bylaws Committee.

PROGRAM COMMITTEE

The Program Committee hereby records for the official record the program arranged for the Annual Scientific Session of the Medical Society of Delaware on November 21, 1998. The overall objective of this annual program is to update Delaware physicians in a broad range of specialties on significance advances in selected areas of medicine.

209TH ANNUAL MEETING

Saturday, November 21, 1998
Hotel du Pont, Wilmington, Delaware

7:30 a.m. - Exhibits — Foyer and Gold Ballroom

8:00 a.m. - Concurrent Workshops (1 1/2 hours each) — Second Floor Meeting Rooms

"Practical Aspects of Joint Aspiration"

James H. Newman, M.D., Rheumatology Associates, Wilmington, DE
Objectives: To learn indications for joint aspiration; learn and practice techniques of joint aspiration; and to learn indications for joint injection.

"EKG Review: A Practical Approach to Interpreting Electrocardiograms"

David S. Grubbs, M.D., Cardiology Physicians, P.A., Wilmington, DE

Objectives: To review basic EKG reading techniques, a practical approach to arrhythmias, and ischemia, infarction, and injury patterns.

"Office Dermatology"

Helen A. Mashek, M.D., Panzer Dermatology Associates, Newark, DE

Objectives: To identify common cutaneous disorders and formulate a differential diagnosis; learn basic pathogenic concepts; and formulate diagnostic and therapeutic plans.

"Cancer Screening: What Should We Be Doing?"

James M. Gill, M.D., M.P.H., Director of Health Services Research and Associate Director of Family Practice Residency Program, Christiana Care Health Services, Wilmington, DE

Joel Chodos, M.D., Private Practice of Gastroenterology, Wilmington/Dover, DE

Objectives: To apply the principles of evidence-based medicine to screening for cancer; review the new screening recommendations of the U.S. Preventive Services Task Force; and discuss specific examples of controversy in cancer screening both for general primary care and for colorectal cancer.

9:30 a.m. Intermission

10:00 a.m.

"Moving End-of-Life Issues Into Mainstream Medicine — A Historical Perspective"

Joseph F. Fennelly, M.D., Attending Physician, Department of Medicine, Morristown Memorial Hospital, Morristown, NJ; Assistant Professor Medicine, College of Physicians and Surgeons, Columbia University, New York, NY

Objectives: To present a historical overview of end-of-life issues and understand the implications of managed care organizations and patient-centered care.

11:00 a.m.

"Potential Impact of Cloning on Human Infertility and Gene Therapy"

Paul G. McDonough, M.D., Professor Emeritus, Departments of Obstetrics and Gynecology, Physiology and Endocrinology, and Pediatrics, Medical College of Georgia, Augusta, GA

Objectives: To understand the mechanics of nuclear transplantation; understand the uses of nuclear transplantation from embryonic cells; and understand the medical and ethical differences between cloning embryonic cells versus somatic cells.

12:00 noon Lunch — Gold Ballroom

12:30 p.m.

"Congenital Heart Disease at the Turn of the Century"

William I. Norwood, M.D., Ph.D., Chief of Cardiothoracic Surgery, The Nemours Cardiac Center, Alfred I. du Pont Hospital for Children, Wilmington, DE

Objectives: To review the developmental history of early congenital heart disease management and future directions and perspectives of this disease, as well as to understand the physiological challenges in managing complex heart disease.

1:30 p.m. Adjournment

The Medical Society of Delaware is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Medical Society of Delaware designates this educational activity for a maximum of 4.5 hours in Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program has been reviewed and is acceptable for up to 4.5 Prescribed hours by the American Academy of Family Physicians.

It is the policy of the Medical Society of Delaware to comply with the ACCME Guidelines for Commercial Support of Continuing Medical Education. In keeping with these standards, all faculty participating in continuing medical education programs sponsored by the Medical Society of Delaware are expected to disclose to the program audience any real or apparent con-

flict of interest related to the content of their presentations.

David D. Biggs, M.D., Co-Chair
David S. Grubbs, M.D., Co-Chair

The report was filed with a commendation to the Program Committee for having put together a very well-rounded series of talks.

PUBLIC AND PROFESSIONAL EDUCATION AND ADVOCACY COMMITTEE

In 1998, the Public and Professional Education and Advocacy Committee (PPEAC) convened quarterly to review the Continuing Medical Education program of the Medical Society of Delaware.

As a contingency to the 1996 award of reaccreditation by the Accreditation Council for Continuing Medical Education (ACCME), the Medical Society of Delaware was mandated to submit a one-year progress report in August 1997. To address ACCME concerns about proper evaluation of CME activities, the Educational Evaluation Subcommittee (EES) was formed to meet and review activities quarterly.

As of October 14, 1998, with the approval of the Educational Activities Subcommittee (EAS) of the PPEAC, the Medical Society had designated 41 individual activities through the end of 1998 (including the second annual Child Abuse Symposium and Society's 209th Annual Meeting), representing about a 44 percent increase from 1997. Fifteen series CME activities were planned for the 1997/1998 academic year, including the annual Down State Lecture Series organized in conjunction with Jefferson Medical College at Beebe, Nanticoke and Kent Hospitals.

The Society sponsored 472.8 hours of instruction, as opposed to 347.05

in 1997. The Medical Society was able to sponsor the majority of programs presented for review, except for one series and two individual activities that did not comply with ACCME standards. EAS members include Brian Aboff, M.D.; Beverly Dieffenbach; Rebecca Jaffe, M.D.; Kent Sallee, M.D., and the PPEAC Chair, Virginia U. Collier, M.D.

The Physicians and Educators for Improved Student Health program had another successful year with 89 talks presented and 13 physician participants during the 1997-98 school year. Drs. David and Ethel Platt were presented with the J. Thompson Brown Award for community service in March 1998. Dr. David Platt was noted for organizing the School Health Talks Program.

The annual Doctor/Lawyer Day held in conjunction with the Delaware Trial Lawyers Association took place on March 11, 1998, at various schools throughout the state. Twenty-nine Medical Society members teamed up with area lawyers to educate children about the health and legal implications of using drugs. Plans have begun to develop the 1999 education day expected to occur on two dates in February.

Virginia U. Collier, M.D.
Chair

The report was filed with commendation to Ms. Coreen Haggerty for her work on continuing medical education and also commendation to Dr. James Reamer for his many years of work on this committee. The Reference Committee also commended Dr. William Boyd in memoriam for his work on this committee.

PUBLIC LAWS AND LEGISLATIVE ACTION COMMITTEES

At the risk of sounding repetitious, I want to express once more my concern for the apathy that physicians in general continue to show. This concern is considerably mitigated by the fact that there is a very powerful and unequivocally committed small group of doctors who continue to do the work and the legislators receive our message nevertheless. A good summary of health care bills has been provided by our Legislative Specialist Phil Corrozi and is available in the office of Mrs. Beverly Dieffenbach.

During the 39th General Assembly, which adjourned during the early morning hours of July 1st this year, we did accomplish quite a bit. SB 20 - Relating to the Board of Medical Practice including subpoena of Peer Review Records. (Blevins) Signed 6/30/97 w/SA1 and HA1.

SB 78 - To allow direct access to OB/GYN's to be designated as PCP's. (Blevins) Signed 7/15/97 w/SA1 and HA1.

SB 85 - To provide immunity for physicians and nurses who volunteer services for persons insurance. (Bair) In Executive Committee.

SB 194 - To provide due process for MCO selection-deselection. (Blevins) SS1 signed.

HB 156 - To provide health insurance parity for mental and physical illnesses. (Maroney) Signed w/H&S w/HA 1,2,3,4,6, HA1 to HA2, SA1.

HB 384 - To require MCOs to offer a Point of Service Plan. (Maier/ DiPinto) In EcDv/B&I Committee.

HB 650 - Relating to time limitations for malpractice actions. (Petrilli) Defeated 6/23/98. Restored 6/24/98, LOT 6/24/98.

HB 673 - To add a representative of the Society to the Workers; Compensation advisory group. (Oberle) Signed 7/13/98.

HB 703 - To amend Med. Pract. Act to require reporting losses of consciousness due to disease of the central nervous system (epilepsy deleted). Signed 7/14/98.

I want to take this opportunity to express my profound gratitude to my Vice Chairmen, Drs. Dorothy Moore and Michael Bradley, and to Beverly Dieffenbach as well as the entire Board of Trustees of the Medical Society who have all supported me throughout my long years of chairmanship. This time I also want to make everybody aware of the fact that Phil Corrozi, our Legislative Specialist, has far exceeded with his accomplishments the expectations that he created when we first interviewed him for the job several years ago. His knowledge of the legislative machinery, his political savvy, his wit and his personality are colossal assets to our Society.

In the area of mental health and protection of rights of individuals to choose physicians and systems, we have a long way to go. I am of the opinion that we have laid the foundation for a shift to the center where fairness and sanity will be restored.

Jorge A. Pereira-Ogan, M.D.
Chair

The report was filed with a commendation to Dr. Pereira-Ogan.

PUBLICATION COMMITTEE/ EDITORIAL BOARD

The Delaware Medical Journal is still in a period of transition. Peter Rocca and I took over as editors last January and have inherited the rich legacy of Wayne Martz. Dr. Martz continues to give us help on

a prn basis.

The major change to *The Journal* is the new cover. This was donated to us by Aloysius, Butler, and Clark Advertising Agency in exchange for advertising space. The frame will remain the same in each issue, but the lower right hand block will reflect some articles in the current issue.

The focus of *The Journal* will change somewhat. We will depart from the tradition of soliciting de novo scientific articles in favor of articles written for the practice of ambulatory care medicine. Many of these will be reviews written by specialists for generalists and other specialists. We hope to cover most areas of common general practice in every 3-5 year period. We will always accept scientific articles as long as they are referable to the practice of medicine. We will be aggressively pursuing specific topics which are of common interest.

The Journal will continue to serve as a forum for interesting issues on the periphery of medicine. In the next issue, we will publish an article and accompanying editorial on assisted living. Mary Francis Lyons, M.D., of Witt/Kieffer, Executive Recruiters, describes what to anticipate from an executive search firm. In future issues we will continue the tradition of previous editors and publish law and medicine articles. Victor Battaglia, Esq., has submitted an especially interesting article on peer review and its implications.

In general, we will make gradual changes to bring medical topics and news to the Medical Society of Delaware.

G. Stephen DeCherney, M.D.
Chair

The report was filed.

REPORTS OF SUBSIDIARY ORGANIZATIONS

CREDENTIALING CONNECTION, INC.

A little more than two years ago, the Medical Society of Delaware announced the creation of **CREDENTIALING CONNECTION, INC.** (CCI), a wholly owned for-profit subsidiary of the Medical Society of Delaware. Credentialing Connection originated as a primary verification service, aimed at serving the needs of managed care organizations, hospitals and other health care facilities. However, during the initial stages of the business, physician practices began voicing a need for a solution to the endless stream of paperwork that was burdening their offices. As a result, Credentialing Connection introduced its application completion service.

Since its inception in 1996 Credentialing Connection has established systems, policies and procedures, distinct services, etc. CCI has also gained considerable experience in the areas of primary verification and application completion. While the service has grown since its introduction two years ago, CCI recognizes that NCQA certification is necessary in order for the Company to be more competitive and marketable to MCOs, hospitals, and health care facilities that are interested in contracting with NCQA certified organizations.

Throughout 1998, BlueCross BlueShield of Delaware and Credentialing Connection held meetings to discuss their shared interest in eliminating the hassle factors associated with credentialing, and relieving providers of burdensome paperwork.

BlueCross BlueShield of Delaware is hopeful that other managed care organizations and health care facilities in the state will follow its lead and enter into a relationship with Credentialing Connection, thereby eliminating the need for multiple applications and requests for information. As a result of this shared interest, CCI has been processing primary verification files on behalf of BlueCross BlueShield of Delaware during the third and fourth quarters of 1998. CCI is hopeful that these files will enable the Company to undergo an audit by the National Committee for Quality Assurance (NCQA) in an attempt to acquire certification. It is anticipated that the BlueCross BlueShield of Delaware files will be completed by the end of November, thus allowing for an NCQA audit in early 1999.

The CCI 1998 Report of Effectiveness provides an in depth review of the performance of the corporation. The review includes complete data for the first three quarters of 1998, as well as some partial data available for fourth quarter 1998. I encourage Medical Society members to contact the CCI office to obtain a copy of this important report.

The two services currently being offered by CCI are the primary verification service and the application completion service. As mentioned previously, Credentialing Connection, Inc. originated as a primary verification service, aimed at serving the needs of managed care organizations, hospitals and other health care facilities. Members of the service simply forward information submitted by a physician or other health care practitioner to Credentialing Connection. Upon receipt of this information, CCI will primarily verify and track the credentials information and provide the hospital, managed care organization, etc. with a final report that includes all necessary information

for the organization to make a decision regarding provider participation.

The application completion service allows members to forward all applications for credentialing and recredentialing to CCI for completion. Upon enrollment, members are asked to complete a comprehensive CCI application, and forward copies of licenses, malpractice insurance, etc. to CCI. This information is then entered and maintained in CCI's confidential database. All information is held in strict confidence between the credentialing office and the physician. Information is released only with the written permission of the physician. The service has been met with tremendous approval from the offices that have joined, and in an attempt to encourage physicians throughout the State to enroll in the program, CCI introduced a reduced rate structure for the 1998-1999 year. Enrollment in the application completion service is now free for members of the Medical Society of Delaware, and \$300 for non-members. Applications are completed at a rate of \$20 per application.

The Medical Society of Delaware House of Delegates elected seven members to the CCI Board of Directors (BOD) during the Medical Society of Delaware's (MSD) Annual Meeting in November, 1996. The BOD met as scheduled during 1997. In November 1997, Gina Bodycot resigned as Director of CCI. Ms. Bodycot was replaced by Lisa Mc Collum. Ms. Mc Collum and the CCI Board of Directors (BOD) met as scheduled during 1998.

Credentialing Connection, Inc., shares the mission of its founder, the Medical Society of Delaware, which is to serve the needs of its physician members. As a result, CCI is planning to enter all of the MSD members' biographical infor-

mation into its comprehensive database (Medical Staff Line) free of charge. CCI is confident that this information will broaden the level of services currently being offered, and add value to the information that has been collected and maintained thus far. It is anticipated that this Quality Improvement measure will be undertaken in the first and second quarters of 1999.

As in the previous two years, Credentialing Connection, Inc. remains committed to delivering quality services with high value and low cost to its clients. It is our goal to make improvements each day in all areas of the business, and continue to grow and build lasting relationships with the clients we serve. I wish to express my gratitude to Lisa Mc Collum for her excellent work and dedication over the past year, without which the successful operation of CCI would not be possible.

Anthony L. Cucuzzella, M.D.
Chairman

The report was filed.

DELAWARE FOUNDATION FOR MEDICAL SERVICES, LTD.

The Delaware Foundation for Medical Services, Ltd. has continued its activities largely directed toward providing health care services to indigent patients. To that end it provided \$10,000 in funding towards Phase I of the Nanticoke Volunteer Project. This project is being coordinated by Society member Francisco J. Rodriguez, M.D., and is referred to as the "El Centro Cultural Project." Phase I of this project entailed development of bilingual telephone referral for Hispanics who are medically underserved in Sussex County. The total proposed funding for this phase of the project is \$73,500.

Eventually, it is hoped that a volunteer health clinic similar to the Claymont Health Services can be established in Georgetown for this at-risk population. In an exercise of fiscal due diligence, the Delaware Foundation for Medical Services attached the following stipulations on the \$10,000 award. These are:

- 1) Should the project be fully funded by the federal government, the funds would be repaid to the Foundation;
- 2) Should the development of the project not proceed as planned, monies would be refunded; and
- 3) Funding would be contingent on receipt of a written plan and proposal from the "El Centro Cultural Project."

In addition to these activities, the Delaware Foundation for Medical Services, Ltd., has also been chosen as a repository for the proceeds of the Anna P. Dillon Trust. This philanthropic trust has been established by the estate of Anna P. Dillon and administered to date by PNC Bank. A stipulation of the Trust includes the provision that the distribution of any funds from the Trust be in consultation with the Medical Society of Delaware. With the transfer of these funds directly to a wholly owned subsidiary of the Medical Society, this process can be more easily facilitated with the potential conservation of resources which can then be redirected towards trust fund grantees. The Directors of the Delaware Foundation for Medical Services, Ltd., have every expectation that this activity will enhance the delivery of health care services to Delawareans and result in overall improvement in the provision of these vital services.

Joseph A. Lieberman III, M.D., M.P.H.
Chair

The report was filed.

DELAWARE MEDICAL EDUCATION FOUNDATION, LTD.

In 1998, the DMEF held two meetings. At the annual meeting on April 1, 1998, Janice E. Tildon-Burton, M.D., was reinstated as Chair with Michael J. Bradley, D.O., retaining vice-chair duties, and Ross E. Megargel, D.O., retaining the position of Secretary/Treasurer. The other members of the DMEF Board are Raafat Abdel-Misih, M.D., Alfonso P. Ciarlo, M.D., Mansour Saberi, M.D., Richard H. Sherman, M.D., and Carol A. Tavani, M.D., with Robbie Chabalko serving as Alliance representative. Samuel Wilson, M.D., of Dover, Delaware, was also elected to the Board of Directors to replace Christopher R. Donoho, Jr., M.D., who resigned in 1997.

One hundred thirty-four people joined the DMEF as members in 1998, 40 more than in 1997, but 40 less than in 1996. From the 1998 Membership Drive alone \$2,906 was collected for the Endowment Fund.

The Delaware Academy of Medicine, University of Delaware, and Medical Society of Delaware remained constituents in a Telemedicine project. This project will eventually allow physicians to interact with colleagues in "real time" at other sites through continuing medical education, clinical diagnosing and committee meetings. In Spring 1998, the Videoconference Committee visited hospitals in downstate Delaware to build rapport, and in late 1998, the program moved into the final phase of developing a Project Implementation Strategy. DMEF is a funding conduit for the Dillon Trust, whose principal of over \$3 million is handled by PNC Bank. Interest from the Dillon Trust provides approximately \$50,000 per year to fund the project.

The DMEF transferred a MSDIS contribution of \$20,000 to fund the Society's Physicians' Health program.

The DMEF hosted some fundraising activities, including a Medical Society of Delaware casual shirt sale. To date, 50 shirts have been sold, varying from windshirts, sweatshirts, polo and denim shirts. In August, the MSD Alliance hosted a Night at the Blue Rocks which raised \$350 for the Foundation.

Janice E. Tildon-Burton, M.D.
Chair

The report was filed.

DELAWARE POLITICAL ACTION COMMITTEE

As in past years, DELPAC's year is best reviewed in terms of efforts made and successes achieved nationally and locally. While DELPAC is affiliated with the Medical Society of Delaware and focuses its efforts in our state, a percentage of the contributions made to DELPAC are shared with AMPAC (American Medical Political Action Committee) so that we will have the voice we need in national political events. This year as in the past, the primary areas of concern were:

Membership and Fundraising: Similar to last year, membership growth in Delaware was slow. This contrasted with the national trends where there were more states meeting their membership goals. Delaware, unfortunately, was not one of them. However, membership increased this year to 108 as compared to last year's 92. Dues were also increased in 1998 for the first time in almost twenty years. Our yearly dues of \$150 for physicians and \$50 for their spouses are now equal to that of other states.

The increase in membership and dues provided DELPAC with more opportunity to support candidates who support the interests of patients and their physicians. This was especially important in this midterm election year. However, more money is needed to get medicine's message out.

In order to increase membership some new approaches were used this year. First, more recruiting mailings were made than in the past. We also tried grassroots recruitment. In one of the mailings two letters were sent. The first was sent to non-members encouraging them to join. The second was sent to members asking them to recruit two new members and enclosed were two DELPAC sign up cards. Thirty new members joined as a result of this effort. We don't know the relative effectiveness of the two different letters. However, some of those who were already members eschewed the missionary role by sending in another contribution. We hope that physician-to-physician recruitment will become more effective in the future and to promote that goal, next year we plan to do telethon recruitment. Those who are members of DELPAC are listed in Appendix A.

Candidate Support: Please refer to Appendix B which is a list of the candidates who received support from DELPAC this year. As this list demonstrates, DELPAC is a non-partisan entity. Support is given to those candidates who share the values of MSD and are interested in the best interests of patients regardless of their party affiliation.

Lobbying and Legislative Physician Program: Mr. Philip Corrozi, our legislative specialist, has very ably represented the MSD for the past six years. This year more than any other, he proved his knowledge of the legislative process and his admirable ability to present the con-

cerns of patients and their physicians to our elected and appointed state officials. The product of his effort is described below; we had many legislative successes this year.

In addition to Mr. Corrozi's efforts, the legislative contacts made by members of MSD who have served as the legislative physicians have also contributed substantially to our political achievements. All of the members of MSD owe a hearty thank you to those who supported our aims by giving their time and effort to this task. Special thanks go to our president, Dr. Stephen Grubbs for the outstanding representation he gave us testifying before our State Legislature.

Successes: This year has been a very successful year for medicine, nationally and in Delaware. As we predicted last year, the movement to regulate managed care has grown so vigorously that no viable candidate can ignore it. Substantial Patient's Rights Legislation has been introduced in the U.S. Congress and in state houses across the nation.

In Delaware, we have also had patient protections introduced and enacted. Prompt payment regulations have been issued by Mrs. Donna Lee Williams, our Commissioner of Insurance who DELPAC supported during her run for office. The "Due Process Bill" (SB 194) that prevents insurance companies from dropping physicians from their panels without an appeal and hearing has been made law. The Mental Health Parity Bill has also been adopted. Additionally, HB 650 which would have repealed the two-year statute of limitations on malpractice claims was defeated through the efforts of DELPAC.

Goals for the Future: In 1999, we face new challenges, seek important legislative goals and must work

to increase membership. We will also have new leadership for DELPAC.

Dr. Steven Edell has agreed to serve as the Chairman of DELPAC for the coming year. Though he is new to this position, he is a model for us all physicians as he has been very active politically for a long time. He has been involved in political campaigns and is friends with many of our most recognized elected officials. Agreeing to help him in his work are Dr. Michael Katz and Dr. Edward Quinn. These two of our colleagues have also been very involved in the political process supporting candidates and their campaigns and will add their good ideas, insight, experience and energy to Dr. Edell's.

The important legislative goals we have for the coming year include: Legislation that will make insurance companies legally liable for the medical decisions they make in denying or altering the diagnostic or care plan a physician prescribes for his or her patient. Such laws have already been passed in other states and the Texas law after which the MSD bill is modeled has been upheld in legal challenge in Federal Court. We also seek law that mandates that "expert witnesses" in malpractice cases be, in fact, experts—that is, be board certified in the same specialty as the defendant, have comparable practice experience, etc. To protect patients in their relationship with their physician, we will again seek legislation requiring insurance companies to offer a point of service option in their plans. Additionally, we aim to have enacted a law that requires physicians who act as medical directors of insurance companies doing business in Delaware and physicians who make diagnoses or direct treatment through telemedicine on patients in Delaware have a full license to practice medicine in Delaware.

We hope to increase the number of MSD members who serve as legislative physicians. Both to encourage and help those interested in joining in this essential work, we plan to hold training sessions to acquaint them with the substance and nuances of the legislation being presented.

Finally, increasing DELPAC membership is a continuing and essential goal. This is one of the most important areas of focus for the MSD identified by those who participated in the Strategic Planning Initiative in March of 1998.

Words of Appreciation: In closing, I wish to thank Beverly Dieffenbach for her help during this busy and productive year. And in DELPAC, as with every MSD endeavor, Mr. Mark Meister is a consistent and essential contributor to all of our successes.

Martin G. Begley, M.D.
Chairman, DELPAC

The report was filed with the suggestion that DELPAC contact the various specialty societies to coordinate legislative agendas.

MED-NET OF DELAWARE

This has been an active year for Med-Net. We now have three physicians organizations to service with the addition of Eastern Sussex PO in Lewes. We began the year with the need to solidify our infrastructure. After many interviews and the diligent effort of the board and Stephen S. Grubbs, MD, MSD President, this task was completed. We now have a complete infrastructural team built from both internal and external components. The team demonstrated great ability throughout the numerous contact discussions over the summer. Special thanks to Dr. Grubbs and Dr. Robert Dressler for their tireless contributions during these months of discussions.

With this objective achieved, we were both complemented and challenged when the Medical Society 1998 Strategic Plan listed as its #1 goal: to assist Delaware physicians in the formation of local, autonomous physician organizations and to obtain at least one contract per network by year end. I am pleased to announce that Med-Net has also successfully met that goal. In early October letters of agreement were signed by the president of each PO for a Risk-Sharing Agreement with a national company. We continue to have meetings with the various insurance carriers and have discussed risk-sharing contracts for both Medicare and commercial plans. We feel that we are making good progress towards these contracts. We also have been looking at non-traditional managed care contracts and believe these may have more benefits to our POs than the original model with which Med-Net was working. This seems to be one of Med-Net's greatest assets; the ability to mold and flex with the changing health care environment.

Med-Net recently repaid \$25,000 to the MSD bringing total repayments for the year to \$27,500. With our current cash reserves and income, we are financially solid through the second quarter of 1999. With the upcoming contracts, we hope to project this even further. Med-Net through its three POs currently represents 437 physicians in Delaware. There is renewed activity in the Dover area of another PO forming. I am personally working hard in that adventure. With the addition of the ESPO, Med-Net has expanded its own Board of Directors to nine members. We currently have six physicians, Jim Wilton, President/CEO and Mark Meister, Secretary/Treasurer, serving on the board. There is one open slot for a businessperson of stature in the local community.

I would like to thank all the members of the board of directors of Med-Net of Delaware for their hard work. Special thanks needs to go to the individual physicians and their POs for believing in the vision of Med-Net and their patient assistance as we labor together to make the vision a reality.

Michael J. Bradley, D.O.
Chairman of the Board

The report was filed. The Reference Committee commended Dr. Bradley and the Med-Net Board. Each physician organization has successfully secured its first contract, meeting Med-Net's established goal of the Medical Society of Delaware's Strategic Plan.

MEDICAL SOCIETY OF DELAWARE INSURANCE SERVICES (MSDIS)

Bottom Line: 1998 will be our fourth year of record revenues, and we are cautiously optimistic the trend will continue next year. In the four years of our Zutz/PLI and RTA relationships, we have seen a trebling of our revenue. We are reaching a plateau in the medical liability business (there is a finite number of physicians). But our *Health Select* line of business continues to grow, and the growth potential for the next several years is extremely high.

We have sold Class B, non-voting shares to the Delaware State Bar Association and the Delaware State Dental Society. This move will open up these societies to our *Health Select* lines of health insurance, as well as certain other insurance products. This area is where we see tremendous growth potential.

We maintain good relations with our current malpractice carriers, PHICO and Princeton. Rates are remaining stable and PHICO has made a \$118,000 dividend refund to policy holders of 1994. While the medical malpractice climate is stable, we realize things can change, and continue to search for

quality insurers. We are especially interested in companies owned/guided by physicians, such as the Medical Society of Washington, D.C.'s captive insurer, NCRIC.

In addition to insurance products, we have broadened our scope and are making available to Society members (401)K pension plans, similar to what we offer MSD employees. This is more a service we can offer our members than a significant profit source, but one your board felt would benefit the membership, especially younger members without an established financial consultant.

The working relationship between Zutz/PLI, RTA and MSDIS has been so synergistic that Zutz/PLI and RTA are forming a joint venture and MSDIS has signed our newest contract with this new entity rather than having separate contracts. By shifting revenue / expense accounting to Zutz/PLI, our records are simplified and will make the quarterly P/L statements far easier to read. Because of the current success with MSDIS, the new Zutz/PLI/RTA venture will begin marketing health insurance products more regionally, and share a portion of this revenue with MSDIS.

This success has been earned by the contributions of Larry Zutz, Frank Wharton and Karen Reuschlein at Zutz/PLI, and the tireless efforts of Mike Taylor, Kent Evans and Susan Karlson of RTA;. As always, Bill Duncan keeps track of both the devil's details as well as the big picture providing continuity and focus. Once again, I wish to extend them my thanks. I wish also to thank the board members who contribute to our success, and special thanks to those who have to make a three to four hour trip for the meetings.

Thomas J. Maxwell, M.D.
President

The report was filed.

REPORT OF THE NOMINATING COMMITTEE

A meeting of the Nominating Committee was held at the Christiana Hilton in Newark on Thursday, October 8, 1998, to consider positions to be filled by the House of Delegates at its meeting on November 20, 1998. The following nominations were made:

President
Martin G. Begley, M.D.

President-Elect
Michael A. Alexander, M.D.

Vice President
Edward F. Quinn III, M.D.

Secretary
Leo W. Rasis, M.D.

Treasurer
Joseph F. Hacker III, M.D.

Speaker of the House
Roger B. Thomas, Jr., M.D.

Vice Speaker of the House
Joseph A. Lieberman III, M.D.

Representative to the Delaware Academy of Medicine
Leslie W. Whitney, M.D.

Delegates, AMA
(two-year terms to expire 12/31/00)
Michael J. Bradley, D.O.
James P. Marvel, Jr., M.D.

Alternate Delegates, AMA
(two-year terms to expire 12/31/00)
Joseph P. Olekszyk, D.O.
Richard P. Simons, D.O.

Judicial Council
(three-year term to expire 11/01)
E. Wayne Martz, M.D.

ELECTED COMMITTEES

(one-year terms)

BUDGET AND FINANCE COMMITTEE

Michael A. Alexander, M.D.
Martin G. Begley, M.D.
Anthony L. Cucuzzella, M.D.
J. Hamilton Easter, M.D.
Stephen S. Grubbs, M.D.
Joseph F. Hacker III, M.D.
Ali Z. Hameli, M.D.
Garth A. Koniver, M.D.
E. Wayne Martz, M.D.
Edward F. Quinn III, M.D.
Richard H. Sherman, M.D.
Janice E. Tildon-Burton, M.D.

COMMITTEE ON ETHICS

Mehdi Balakhani, M.D.
Louis E. Bartoshesky, M.D.
Rhoslyn J. Bishoff, M.D.
Neal B. Cohn, M.D.
Garrett H. C. Colmorgen, M.D.
Evan H. Crain, M.D.
Daniel L. DePietropaolo, M.D.
The Honorable Joseph G. Di Pinto
Paul T. Durbin, Ph.D.
Robert W. Frelick, M.D.
Donald A. Girard, M.D.
John J. Goodill, M.D.
Michael J. Guarino, M.D.
Dennis J. Hoelzer, M.D.
William L. Jaffee, M.D.
Paul F. Kaminski, M.D.
Maurice Liebesman, M.D.
Peter B. Panzer, M.D.
Stephen R. Permut, M.D.
Brother John Pumphrey
Anne Reilly, M.D.
Peter Schindler, M.D.
M. Eileen Schmitt, M.D.
Stuart Septimus, M.D.
Thomas A. Sweeney, M.D.

MEDICAL SOCIETY OF DELAWARE SUBSIDIARY ORGANIZATION BOARD MEMBERS

MEDICAL SOCIETY OF DELAWARE INSURANCE SERVICES (MSDIS)

BOARD OF DIRECTORS (one year terms)

Robert G. Altschuler, M.D.
Thomas W. Fiss, Jr., M.D.
Paul E. Howard, M.D.
Joseph F. Kestner, Jr., M.D.
James P. Marvel, Jr., M.D.
Michael L. Mattern, M.D.
Thomas J. Maxwell, M.D.
Mr. Mark A. Meister
Rafael A. Zaragoza, M.D.
William H. Duncan, M.D., Emeritus
with vote

CREDENTIALING CONNECTION (three-year terms)

Anthony L. Cucuzzella, M.D.
James P. Marvel, Jr., M.D.

DELAWARE FOUNDATION FOR MEDICAL SERVICES (three-years to expire 12/31/01)

William Ellert, M.D.
Stephen R. Permut, M.D.
Francisco J. Rodriguez, M.D.

MED-NET OF DELAWARE (three-year terms)

Stephen S. Grubbs, M.D.
Richard P. Simons, D.O.

Respectfully submitted,

Martin G. Begley, M.D., Chair
Cynthia Heldt, M.D.
Joseph P. Oleksyk, D.O.
Brian J. Walsh, D.O.
Stephen F. Wetherill, M.D.

The report of the Nominating Committee was adopted by the House of Delegates.

RESOLUTIONS ADOPTED BY THE HOUSE OF DELEGATES

RESOLUTION 98-1

Introduced by:
Board of Trustees

Subject:
AMA Unification

Whereas, it is the policy of the House of Delegates to reconsider AMA unification every three years; and

Whereas, this issue is scheduled to be voted upon by the House of Delegates at its 1998 annual meeting; and

Whereas, an ad hoc committee was formed by the Board of Trustees to render a report to assist the Board in its deliberations regarding its position relative to the continuation of this policy; and

Whereas, the ad hoc committee was comprised of an equal number of AMA Delegates and those who have chosen not to remit AMA dues for the current dues year; and

Whereas, the ad hoc committee identified substantial benefit to the Medical Society associated with AMA unification, such as: increased representation by Delaware physicians at AMA House of Delegates meetings; increasingly prominent roles played by Delaware physicians at such meetings; and increased responsiveness by AMA staff in providing assistance to the Society on legal, political and ethical issues; and

Whereas, the ad hoc committee noted that the Society's unified dues structure is at the median of the combined state and county dues

for most other metropolitan areas in the country and is the third lowest of all state medical societies in the country; and

Whereas, at its meeting on October 8, 1998, the Board of Trustees endorsed the existing AMA unification policy; now therefore be it

Resolved, that the Board strongly encourage the House of Delegates to vote in favor of continued AMA unification.

The Reference Committee commended Dr. Stephen Permut and the members of the Ad Hoc Committee for their excellent work on the very difficult and important issue of AMA unification.

The Reference Committee recommended that Resolution 98-1 be approved. There was a wide variety of opinions regarding opposition to unification. The AMA was encouraged, as part of its reformation and reorganization, to promote itself more to its membership.

Resolution 98-1 was adopted by the House of Delegates.

RESOLUTION 98-2

Introduced by:
Thomas A. Sweeney, M.D.

Subject:
Ambulance Personnel

Whereas, the Department of Transportation Emergency Medical Technician-Basic (EMT-B) curriculum is accepted throughout the United States as the minimum for ambulance personnel charged with the assessment and treatment of patients with emergency medical conditions; and

Whereas, the National Registry of Emergency Medical Technicians offers a widely accepted objective

written and practical certification testing process; now therefore be it

Resolved, that the Medical Society of Delaware support the initiative of the Delaware Volunteer Fireman's Association and the Delaware Fire Prevention Commission to mandate that by January 1, 2002, every citizen of Delaware who needs to utilize an ambulance will be guaranteed that the primary patient caregiver on that ambulance has completed a course of training taught to the U.S. Department of Transportation EMT-Basic Level and has passed the objective, standardized, national written and practical certification evaluation process as promulgated by the National Association of Emergency Medical Technicians.

The Reference Committee recommended adoption of Resolution 98-2.

Resolution 98-2 was adopted by the House of Delegates.

RESOLUTION 98-3

Introduced by:
Young Physicians Section

Subject:
School Bus Safety

Whereas, our State's most precious resource, children, ride school buses to and from schools and extracurricular events; and

Whereas, a CNN study found a 94 percent increase in injuries to students riding school buses over a 12-year period from 1985 through 1996; and

Whereas, in the 1995-1996 school year, there was a national total of 30,800 school bus accidents with 16 child fatalities; and

Whereas, the National Highway Traffic Safety Administration advocates school bus "compartmentalization" as an effective way to keep children safe on school buses (a seating design meant to keep children from being thrown around inside the bus with the seat back in front of the child slightly padded); and

Whereas, only two states, New York and New Jersey, require seat belts on newly purchased school buses and a study by the New Jersey Institute of Technology in 1989 calculated 70 percent of all deaths and 64 percent of the serious injuries happen in side-impact crashes or rollovers because the seat-back concept offers little protection to an unrestrained child; and

Whereas, the American Medical Association, American Academy of Pediatrics, American College of Emergency Physicians, American Society for Adolescent Medicine, American College of Preventive Medicine and Physicians for Automotive Safety all favor seat belts in school buses; and

Whereas, the last time real-life crash tests done on school bus safety were in a 1967 UCLA test; now therefore be it

Resolved, that the MSD-YPS ask the MSD to create model state legislation and recruit representative sponsors to conduct or commission a study to: evaluate school bus structure and safety; the need for a redesign of school bus construction to meet or exceed automobile safety standards; and the need for child restraint systems on all current school buses. The MSD should have the Model legislation prepared and sponsored for the next session of Delaware's General Assembly.

The Reference Committee recommended the adoption of substitute resolution 98-3 to read:

Resolved, that the Medical Society of Delaware ask the American Medical Association to petition the National Transportation Safety Board to conduct a study to evaluate school bus structure and safety and the need for child restraint systems on all current school buses and propose national standards for use in national legislation; and be it further

Resolved, that the Medical Society of Delaware AMA Delegates present this resolution at the upcoming AMA House of Delegates Interim Meeting this December; and be it further

Resolved, that the Medical Society of Delaware work with the state legislature to create state legislation based on the national guidelines of school bus safety restraint systems.

Substitute Resolution 98-3 was adopted by the House of Delegates.

RESOLUTION 98-4

Introduced by:
Delaware Foundation for Medical Services, Ltd.

Subject:
Voluntary Initiative Program for the Uninsured

Whereas, the number of uninsured residents in our state continues to increase; and

Whereas, access to necessary medical services for this population continues to be of growing concern among the state's medical care providers, policy makers and government officials; and

Whereas, the Medical Society of Delaware, through its Voluntary Initiative Program (VIP), made significant contributions to increased ac-

cess to care for Medicaid recipients at a time when such access was severely limited; and

Whereas, the Medical Society retains the expertise and facilities to implement the VIP for uninsured Delawareans who are unable to afford basic primary and preventive medical care; and

Whereas, the Delaware Foundation for Medical Services, Ltd. is willing and prepared to provide financial assistance to the Society for administration of the VIP for the uninsured; and

Whereas, passage of the Federal Volunteer Protection Act of 1997 affords immunity to physicians who provide medical services without compensation to patients qualified for participation through a program such as the VIP; now therefore be it

Resolved, that the House of Delegates support implementation of the VIP for the uninsured residents of our state, who are determined by the Delaware Department of Health and Social Services to qualify for participation based on family income; and be it further

Resolved, that the Delaware Foundation for Medical Services, Ltd. Board of Directors be responsible for overseeing the timely implementation administration of this program.

The Reference Committee recommended adoption of a substitute resolution 98-4 with the following additional **Resolveds**:

Resolved, that the Medical Society of Delaware's Board of Trustees through the Medical Care Advisory Committee, continue to support expanding eligibility criteria for more uninsured Delawareans; and be it further

Resolved, that the Society foster and encourage the involvement of

all sectors of the health care industry in this voluntary initiative program for the uninsured.

Substitute Resolution 98-4 was adopted by the House of Delegates.

RESOLUTION 98-5 (Late Resolution)

Introduced by:
Rhoslyn J. Bishoff, MD

Subject:
Scientific Tracking of Managed Care Complaints

Whereas, managed care plans don't track the outcomes of their denials; and

Whereas, managed care companies don't have to know, much less confront, the consequences of such; and

Whereas, no results have been reported on denials that neither change the treatment of patients nor caused undue risk to patients and their families; now therefore be it

Resolved, that the Board of Trustees of the Medical Society of Delaware be directed to establish a means for physicians throughout the state of Delaware to report and record the tracking of all managed care, including Medicare and Medicaid, denials and their outcomes.

Because Resolution 98-5 was a late resolution, it would have been necessary for the Reference Committee to recommend that it be presented to the House of Delegates as an emergency resolution. The Reference Committee did not feel this resolution should be handled as an emergency resolution.

However, there was unanimous agreement by the Reference Committee that tracking of denials of care is an important issue. The Reference Committee felt that

some system to track such denials should be instituted and recommended that the author of the resolution present his idea to the Board of Trustees or to one of the committee of the Medical Society for consideration.

The recommendation of the Reference Committee was adopted by the House of Delegates.

APPENDIX A 1998 DELPAC CONTRIBUTIONS As of November 19, 1998

Raafat Z. Abdel-Misih, MD
Mrs. Manuel G. Abello
Manuel G. Abello, MD
Michael A. Alexander, MD
Edward L. Alexander, MD
Robert G. Altschuler, MD
Barry L. Bakst, DO
Sidney B. Barnes, MD
Thomas P. Barnett, MD
Martin G. Begley, MD
Rhoslyn J. Bishoff, MD
Bikash Bose, MD
Michael J. Bradley, DO
Mrs. Philip R. Bromage
Philip R. Bromage, MD
Brian E. Burgess, MD
Janis G. Chester, MD
Alfonso P. Ciarlo, MD
Ben C. Corballis, MD
Anthony L. Cucuzzella, MD
Richard T. D'Alonzo, MD
Charles A. Depfer, DO
A. N. DeSanctis, MD
Beverly Dieffenbach
Steven L. Edell, DO
Brett Elliott, MD
Ronald Ellis, MD
Lennart Fagraeus, MD
Richard A. Falcioni, PA-C
Timothy J. Felker, MD
Marciana D. Filippone, MD
Thomas W. Fiss, MD
Anthony B. Furey, DO
Maribel Garcia, MD
William J. Geimeier, MD
Arnold B. Glassman, DO
Joel S. Golden, MD
Edward J. Goldstein, MD
Mrs. Jose Gontang
Jose R. Gontang, MD
John J. Goodill, MD
Paul E. Gorrin, MD
Angelo Grillo, MD
Stephen S. Grubbs, MD
Nam S. Han, MD
Paul E. Howard, MD

Janine C. Islam, MD
David M. Islam, MD
Leonard I. Japko, MD
Neil B. Jasani, MD
Beth F. Jones, DO
Jonathan W. Kamen, DO
Steven M. Katz, MD
Michael S. Katz, MD
Neil S. Kaye, MD
Joseph F. Kestner, MD
Kyo A. Kim, MD
Edward J. Knox, PA-C
Paul C. Kupcha, MD
Steven Kushner, MD
Harry A. Lehman III, MD
Vincent G. Lobo, DO
John F. Madden, MD
Vicenta G. Marquez, MD
James P. Marvel, MD
Bonnie B. Matthaeus, MD
Robert L. Meckelnburg, MD
Otto R. Medinilla, MD
Mark A. Meister, Sr.
Jacob W. Miller, Jr., DO
Paul W. Montigney, MD
Dai O. Moon, MD
Dorothy M. Moore, MD
Sunanda Nabha, MD
Leonard A. Nitowski, MD
Clement Ogunwande, DO
Louis F. Owens, MD
Jorge A. Pereira-Ogan, MD
Stephen R. Permut, MD
Gregory W. Price, MD
Mrs. Edward F. Quinn
Edward F. Quinn, MD
Leo W. Rasis, MD
Gordon D. Reed, MD
Mario M. Rosales, MD
Mrs. Glen D. Rowe
Glen D. Rowe, DO
Mrs. Joseph F. Rubacky
Joseph F. Rubacky III, DO
Mrs. Anis Saliba
Anis Saliba, MD
Jonathan N. Saunders, MD
William J. Schickler, MD
Richard H. Sherman, MD
Richard L. Sherry, MD
Paul A. Sica, MD
Richard P. Simons, DO
Narinder G. Singh, MD
Bruce H. Sokoloff, MD
David T. Sowa, MD
John R. Stump, MD
V. R. Sukumar, MD
Thomas A. Sweeney, MD
Carol A. Tavani, MD
Roger B. Thomas, Jr., MD
Janice E. Tildon-Burton, MD
Donald C. Tilton, DO
Ross M. Ufberg, MD
Thomas E. Vaughan, MD
Joseph T. West, MD

Stephen F. Wetherill, MD
Andrew A. Willet, MD
Samuel M. Wilson, MD
David Wolman, PA-C
Rafael A. Zaragoza, MD
William M. Zeit, MD
Marc T. Zubrow, MD

APPENDIX B DELPAC CONTRIBUTIONS SINCE CANDIDATE'S LAST ELECTION

As of November 3, 1998

General Assembly Candidates

Patricia M. Blevins (D)* — 7th Sen.
Colin R. J. Bonini (R) — 16th Sen.
Timothy U. Boulden (R) — 22nd Rep.
Deborah H. Capano (R) — 12th Rep.
V. George Carey (R) — 36th Rep.
Catherine Cloutier (R) — 11th Rep.
Dori Connor (R) — 12th Sen.
Richard A. DiLiberto, Jr. (D) — 14th Rep.
Joseph G. Di Pinto (R) — 2nd Rep.
David H. Ennis (R) — 6th Rep.
Benjamin J. Ewing, Jr. (R) — 35th Rep.
Tina Fallon (R) — 39th Rep.
Robert F. Gilligan (D) — 19th Rep.
Margaret Rose Henry (D) — 2nd Sen.
Clifford G. Lee (R) — 40th Rep.
Pamela S. Maier (R) — 21st Rep.
Joseph E. Miro (R) — 22nd Rep.
William O. Murray (R) — 38th Rep.
William A. Oberle, Jr. (R) — 24th Rep.
Donna Reed (R) — 11th Sen.
Roger P. Roy (R) — 20th Rep.
Michael J. Ramone (R) — 22nd Rep.
George Robert Quillen (R) — 30th Rep.
Arthur L. Scott (D) — 3rd Rep.
John R. Schroeder (D) — 37th Rep.
Wayne A. Smith (R) — 7th Rep.
Liane Sorenson (R) — 7th Sen.
Terry R. Spence (R) — 18th Rep.
John C. Still III (R) — 17th Sen.
Stephanie A. Ulbrich (R) — 25th Rep.
Robert J. Valihura, Jr. (R) — 10th Rep.
John F. Van Sant (D) — 13th Rep.
Nancy H. Wagner (R) — 31st Rep.
Dennis P. Williams (D) — 1st Rep.
Dallas Winslow (R) — 4th Sen.

Of the candidates that DELPAC supported who had opponents in the general election, only two were defeated (Murray, Reed).

Also:

Democrats '98
Republican Legislative Campaign
Committee

AWARD PHOTOS

Delaware Democratic State Committee
Republican Committee of Delaware
Democratic Legislative Campaign
Committee

Ruth Ann Minner (D) — Lt. Governor*
Jack Markell (D) — Candidate for State
Treasurer
Donna Lee Williams (R) — Insurance
Commissioner*

The DELPAC Board also voted to support M. Jane Brady (R), the winning candidate for Attorney General, but the Brady campaign chose not to accept contributions from political action committees.

* = term ends in 2000



Jane Maroney was presented with a resolution in appreciation for her many legislative accomplishment in the health care arena.



Philip J. Corrozi received the prestigious President's Award for his legislative work on behalf of Delaware's medical professionals.



Katherine L. Esterly, MD received the Daniel A. Alvarez MD Distinguished Service Award for her dedicated service to the profession of medicine and the citizens of Delaware.



Past Society President Stephen R. Permut, MD received a citation from the President and Fellows of the Medical Society of Delaware for his outstanding contribution of time and service to the society.

MEDICAL SOCIETY OF DELAWARE

Pictorial Roster 1999-2000

The Medical Society of Delaware's pictorial roster is an invaluable resource to Society members, medical community members, and others in need information about Delaware's physicians.

Format

The format of the 1999-2000 roster offers even more information, including e-mail addresses. Housed in an efficient three-ring binder, the roster allows for easily adding or removing pages. Home address information for Society members is available as a separate, bound publication that can be easily inserted into the roster or kept separate for home or office use.

The Roster is ordered as follows:

 **MEDICAL SPECIALTIES**
Alphabetically listed by county

 **MEMBERSHIP DIRECTORY**
Alphabetically listed within county

- Name and degree
- Professional addresses, phone & fax numbers, e-mail addresses
- Type of practice and year board-certified
- Medical school and year of graduation

If the physician is board certified in a specialty, the year in which the certification was earned will follow the specialty in parentheses. Unless the entry indicates otherwise, the board certification was granted by the American Board of Medical Specialties.

OTHER INFORMATION

An alphabetical listing of medically related groups and organizations

- Hospital Information
- Medical Libraries
- Nursing Homes, Extended Care Facilities and Retirement Homes
- Insurance Carriers
- Other Facilities, Organizations and Services
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- Chaplains
- Physicians' Health Hotline

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The Business of Medicine

(J.K. Silver, M.D. - Hanley & Belfus, Inc. Publishers - Philadelphia, PA - 1998)

Leroy R. Kimble, M.D.

This book deals with the drastic changes that have taken place in the practice of medicine over the past 30 years. Even today, the changes are continuing. It has been a well known fact that most physicians do not have a very good business background. This book should make a physician realize the many facets of not only the practice of medicine, but the administration and management of a practice.

Physicians who are starting out in practice should first read this book. Better yet, introducing this book to residents and even senior medical students would be worthwhile.

There are over 30 contributors to this book, all having a great deal of experience in the business of medicine. Advice is for both solo and group practices.

Leroy R. Kimble, M.D., is a retired Family Practitioner and a member of the Medical Society of Delaware.

The workings of various organizations (HMOs, IPOs, Managed Care, etc.) are discussed fully. The pros and cons of what to look for, and understanding before signing contracts are important. There are discussions about malpractice, court proceedings, management of an office, applying for an industrial or hospital position, group practices, and rural practices. Suggestions on patient care include showing more compassion and taking plenty of time to listen to the patient.

Understanding the Business of Medicine would enhance the patient-physician relationship and is a very good reference for every physician's bookshelf.

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INFORMATION FOR ADVERTISERS

The *Delaware Medical Journal* is a monthly publication of the Medical Society of Delaware. The *Journal* reaches approximately 80 percent of the state's physicians, as well as medical libraries, and hospitals; its circulation is approximately 1,700.

Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

Closing for space reservations is the first of the month, two months prior to publication. Closing for materials is the first of the month, one month prior to publication.

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For a media kit or for more information, call Kristine Riccardino at 302-658-7596 or 800-348-6800 (Kent or Sussex Counties).

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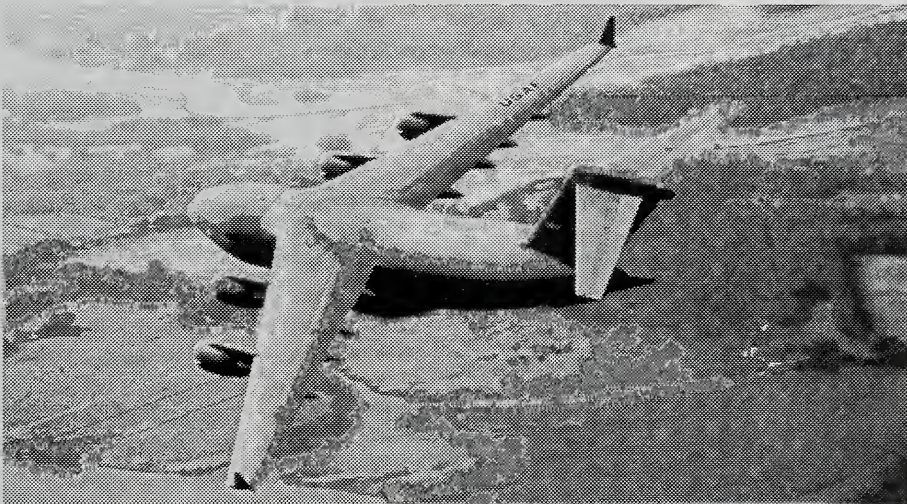
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Suite 100, Bldg. 4,
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- **HealthCare Center at Christiana,**
200 Hygeia Drive,
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(302) 421-2121

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DELAWARE

MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE MEDICAL SOCIETY OF DELAWARE

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Cerebral Aneurysms



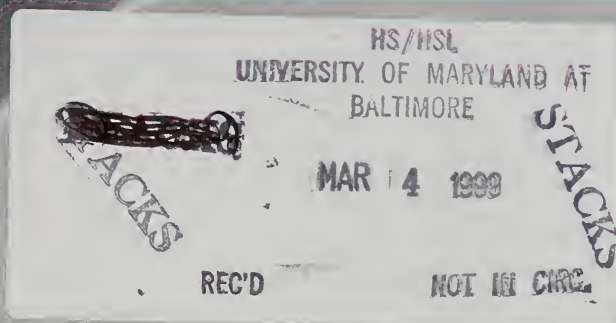
Stroke: No More Diagnose
and Adios



Scientific Sessions
Recap



Proceedings from the
1998 House of Delegates
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Nuclear Medicine

Abcess Localization

Brain Scan

Bone Scan

Breast Imaging (Miriluma)

First Pass

Gastric Emptying Scan

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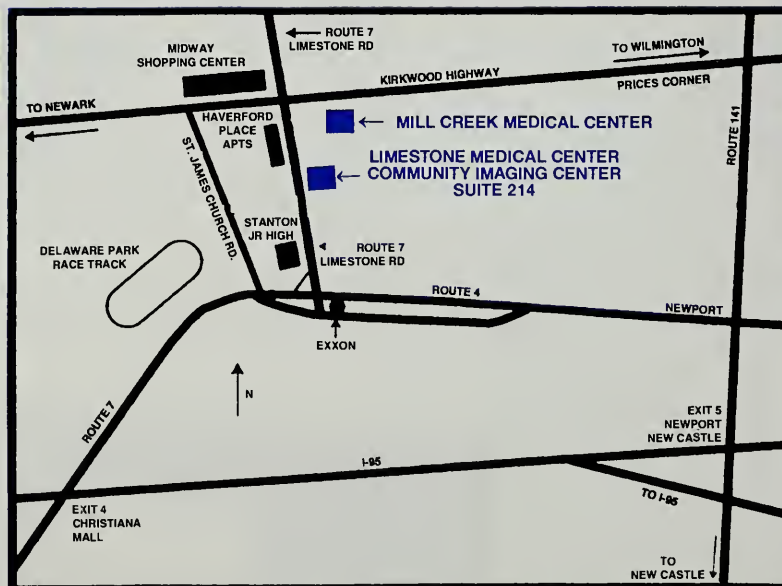
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Scientific articles on medical matters are especially welcomed, including case reports, clinical experiences, observations and information on matters relevant to medical practice. Other material may also be accepted if the editorial staff deems it of interest to *DMJ* readers. All submissions should include a brief summary and a brief (one to two sentence) biographical sketch of all authors.

It is highly recommended that authors familiarize themselves with *DMJ* style before submitting manuscripts for consideration.

All material for publication should be submitted on a 3 1/2" computer diskette in Word 6.0. A printout of the manuscript must accompany the disk. Manuscripts may also be submitted in paper form (typed or printed out on good-quality paper - one side only, one-inch margins), though computer disk is preferable. The ideal manuscript length is two to 12 pages with up to 12 references, each keyed with superscripts in the text in the order cited. The format should follow that used in the *Index Medicus*. Authors are responsible for the accuracy of the citations.

Graphs, charts and black-and-white glossy photographs are accepted if important to the understanding of the text, but should not exceed four or five pieces. Each should have a label affixed on its back indicating its name, number, and "top." A separate legend should be provided for each. Do not write on the back, or scratch or mar them using paper clips. Do not mount them on cardboard.

Photos of patients should generally be taken in a way that obscures the patient's identity. Photos in which a patient's face must be clearly seen, however, must be accompanied by signed release forms.

All manuscripts are reviewed by the editor and all scientific articles are then sent for peer review by members of the Editorial Board and/or other appropriate physicians. The usual processing time to publication is two to four months, though in some circumstances this may be longer or shorter.



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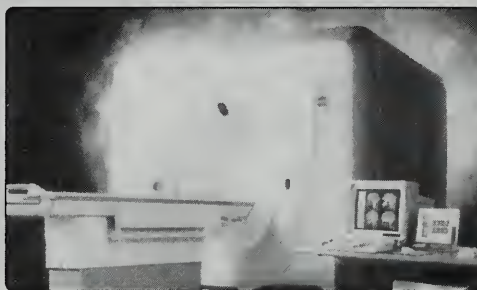
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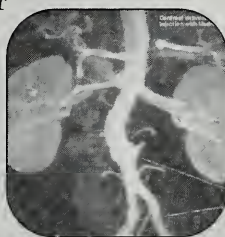
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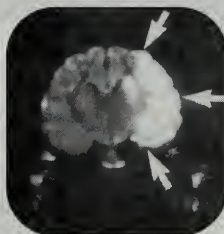
The Advantages include; larger bore opening (60cm as compared to open MRI 47cm) allowing greater comfort for claustrophobic patients, highest possible image quality, plus new exams, such as, MR Urography, MRCP and 3D contrast enhanced MR angiography.



angiogram

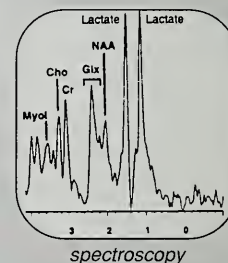
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Brain perfusion can be evaluated by using first-pass Gadolinium without a radioactive substance, thereby, aiding in the early detection of brain tumors or lesions. This image shows a CVA not detected on routine MRI or CT.



early stroke

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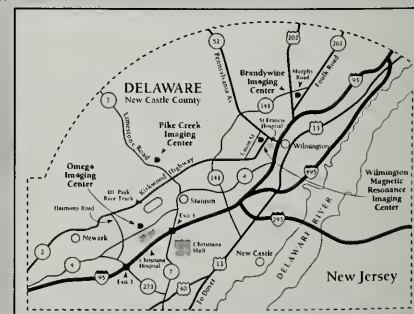
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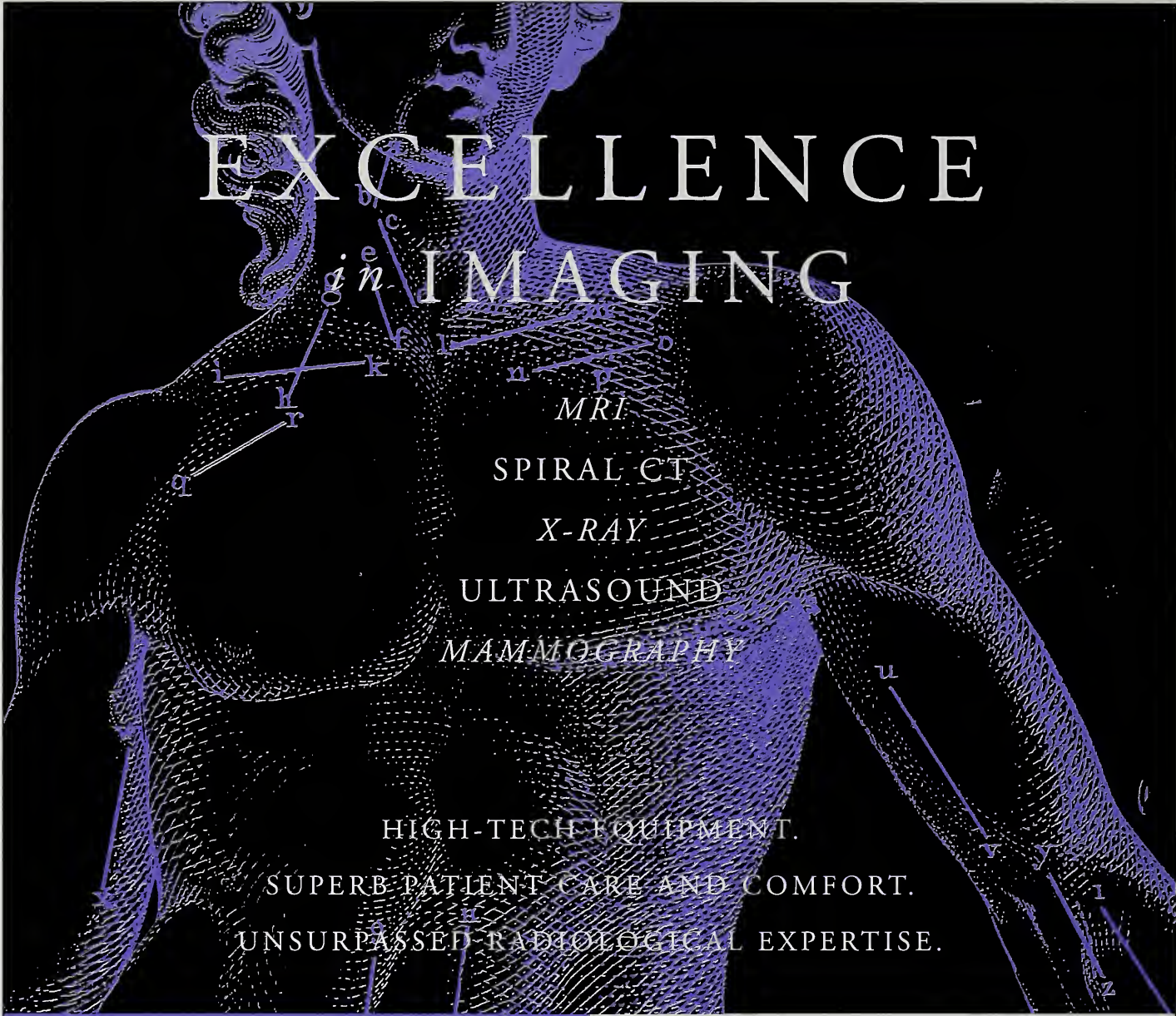
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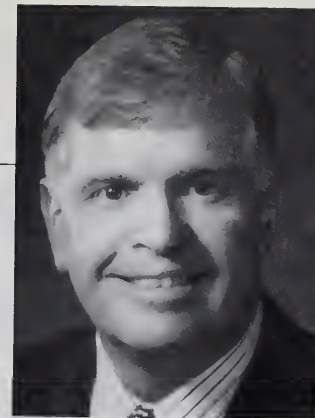
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Health Care Policy You Can Create It!

Martin G. Begley, M.D.



When discussing coverage policies of the Medicare program, physicians are tempted to use words forbidden in broadcasts. If spoken, these expletives usually punctuate reasonable observations that bureaucrats should seek practicing physicians' guidance when these policies are being developed and that it's impossible for those in Washington to determine what is best for the whole country. Hearing this, bureaucrats may be shocked or annoyed because federal law already requires the insurance companies who administer Medicare (a.k.a. "carriers") to obtain local physicians' advice when formulating benefit policy. We physicians have to understand this mechanism as it offers an important opportunity to improve our patients' access to care.

In 1993, the U.S. Congress mandated that most policies (over seventy five percent) defining Medi-

care benefit coverage must be reviewed by local physicians in each state before their adoption. To do these reviews, each Medicare carrier had to form a Carrier Advisory Committee (CAC, pronounced "kack" rhyming with "tack") in every state. Each CAC must have practicing physicians, representing all of the medical and surgical specialties, and meet three times a year. Two weeks prior to the meeting, draft copies of the policies to be reviewed are sent to the CAC members. The policies are modified at the meeting following which there is a thirty day period during which CAC members or any other physician can submit comments and suggestions. Taking into account all comment, the medical directors of the carrier company then write the final policy.

In addition to commenting on policies already chosen for review, individual or groups of physicians can recommend new policies or changes to other existing policies through their CAC. In

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this way, new diagnostic and therapeutic regimens can be introduced and old ones modified. So, physicians have opportunity to profoundly impact Medicare policy and improve access to care for their patients.

Sounds great; so what's the catch? Well, regrettably, nationwide many physicians don't know that this Medicare policy exists and sometimes it has been used feebly, if at all. In states other than Delaware, there have been instances when the specialist with the most to offer in the formulation of a policy, failed to meet with the CAC and never submitted comments or suggestions.

Fortunately, Delaware has a better story to tell. Here, physicians have been represented admirably by our colleagues who are members of our CAC, and Dr. William Nottingham who was chairman since its inception. Recently, Dr. Peter Panzer, another very able and experienced CAC member has succeeded Dr. Nottingham at the helm of this committee.

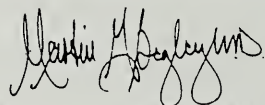
The most significant improvement that all states must make, however, is getting ongoing involvement of physicians other than the CAC members in this process. Without it, we fail to use their insight, experience and considerable talent. To correct this in Delaware, the MSD will announce, via broadcast fax, which policies are under review during each policy review period approximately two weeks prior to each CAC meeting. The draft copies of the policies are available for review through your specialty's CAC representative or at the MSD offices if you wish to see them. Your suggestions can be E-mailed to ama@medsocdel.org or "snail" mailed to the MSD offices. Please label them "ATTN: CAC" for speedy handling. MSD members may also contact their specialty representatives to make suggestions.

Through their medical director, Dr. Michael Riisager, I have requested that in the future

Delaware's carrier, TrailBlazer Health Enterprises, Inc., make the draft policies available for physicians' review on the Internet during the forty-five day review and comment period. Dr. Riisager believes that this can be done. Dr. Riisager, who practiced general surgery for twenty-two years prior to practicing administrative medicine, gives considerable time, interest and energy to this task. He's dedicated to making the process work for the benefit of patients and physicians. He has even offered to hold a special meeting with representatives of specialty groups when there is a policy that would dramatically affect their patients.

The Medical Society of Delaware will continue to focus on this project with the following aims. First, we can improve our Medicare patients' access to care. Second, by having all Delaware physicians participate in the development of these policies we can refine the channels of communication we have among our membership. This was one of the goals considered essential by those who met last year to develop the MSD's Strategic Plan.

Finally, every insurance carrier should have some form of CAC. Then, those who really understand Delaware's patients' needs would guide all medical insurance benefit policy. Otherwise accounting groups will have the biggest say in determining these policies. They are only mindful of the insurance companies' bottom line and often use data derived from that modicum of junk science found in non-juried medical journals or isolated reports that don't represent the standard of care in any community. We have to put an end to that kind of policy development. Our patients deserve more. We must seek it for them by recognizing and using our opportunities to improve health care policy.



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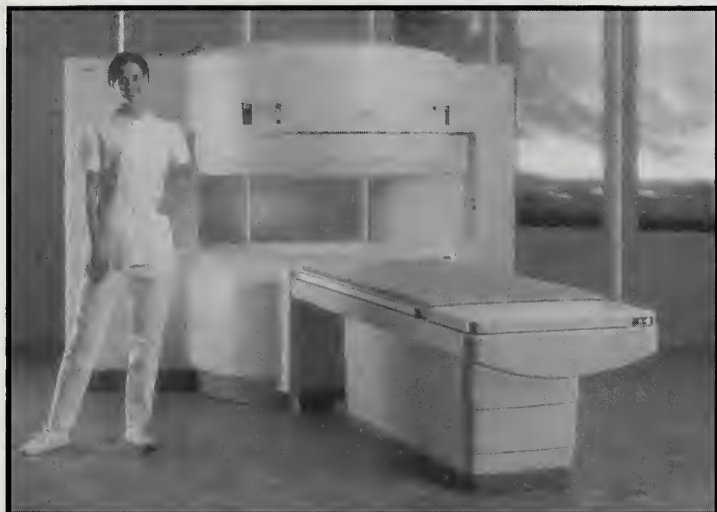
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An Overview of Cerebral Aneurysms Which Factors Affect the Outcome of Microsurgical Treatment

Bikash Bose, M.D., F.A.C.S. — Michael Balzarini, R.N., M.S.N., F.N.P.-C

There is a higher incidence of subarachnoid hemorrhage (SAH) with advancing age.

Considerable controversy exists as to whether aggressive therapy is indicated in the elderly. With increased life expectancy, a greater number of elderly patients with SAH will require treatment in the future. This study was undertaken to evaluate the effect of age, aneurysm characteristics, Hunt-Hess grade on admission, race, and smoking status to the eventual outcome. The results of 76 consecutive aneurysms clipped in 67 patients by a single surgeon (B.B.) were analyzed. Among the variables, Hunt-Hess grade at admission seemed to be the only significant factor influencing the outcome in this series ($X^2_{MH} = 17.136, p < 0.001$). Advancing age did not worsen the prognosis after SAH and therefore age should not be a contraindication for aggressive management.

INTRODUCTION

Every year 30,000 people suffer subarachnoid hemorrhage (SAH) in the United States.⁵ Aneurysmal subarachnoid hemorrhage is a vicious, devastating disease; only 30 to 40 percent of patients who sustain rupture of an aneurysm are able to return to their premorbid condition. With neurological impairment for many of the survivors, other systems including cardiovascular, respiratory, and endocrine may also be affected.¹

When an aneurysm occurs, there is a disruption of the internal elastic tissue of the cerebral vessels creating a dome or balloon that is the

aneurysm. Continued stress on that area, and weakness, may eventually lead to rupture or increasing growth of the aneurysm. Inflammation of the vascular wall, atherosclerotic lesions, or hypertension can also be contributing factors to the continued breakdown of the vascular wall.⁴

A large number of aneurysmal sub-arachnoid hemorrhage (SAH) patients belong to the elderly age group. However, there is considerable controversy regarding whether advancing age should be considered a risk factor for poor outcome after aneurysmal SAH. More recent data show that older patients do as well as their younger counterparts, and age should not be a contraindication for aggressive management. In this study, treatment outcomes were assessed one year postoperatively based on return to work status or daily physical activity levels and self care capacity. Chi-Square test

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and Pearson or Mantel-Haenszel test was used to compare the outcomes among different patient groups.

MATERIALS & METHODS

The results of 76 consecutive aneurysms clipped in 67 patients by a single surgeon were analyzed. Fifty-five patients had subarachnoid hemorrhage while it was incidentally found in 12 patients. Fifty were females (74.63 percent) and 17 were males (25.37 percent). The age range was 25-84 years. The median was equal to 55 years. Other factors: 76.12 percent were white; 22.39 percent were black; and 1.49 percent were Hispanic. Twenty-three (34.33 percent) were smokers; 22 (32.84 percent) had hypertension. Fifty-nine (88.06 percent) patients had a single aneurysm; 10.45 percent had multiple. Twenty-seven were small in size (less than four mm); 43 were medium (4.1 - ten mm); and six were large (greater than ten mm).

In good grade patients, Hunt-Hess Grade I to III, the ruptured aneurysms were clipped within 48 hours of admission. All patients in this series had a diagnosis of ruptured cerebral aneurysm made in the Emergency Room after a CT scan. The patient was admitted to the intensive care unit and standard subarachnoid hemorrhage precautions were instituted. NIMOTOP 60 mg was administered every four hours sublingually and was withheld only if the systolic blood pressure was lower than 100. Cerebral arteriogram was performed as soon as possible and most of the ruptured aneurysms were clipped within 48 hours of admission. The patient was placed on Amicar loading dose of four grams over the first hour followed by 1.5 grams per hour continuous infusion. The Amicar infusion was discontinued as soon as the aneurysm was surgically obliterated in the operating room. A standard fronto-temporal craniotomy was used to treat anterior circulation aneurysms. The Pterional-subtemporal craniotomy was used to clip the basilar artery aneurysms. Posterior and suboccipital far lateral approach was used to clip the vertebral artery aneurysm. Ventricu-

Table 1. Patient Characteristics

Variable	No. of Patients	Percent (%)
Gender		
Male	17	25.37
Female	50	74.63
Age (years)		
<50	28	41.79
50-64	24	35.82
≥65	15	22.39
Race		
White	51	76.12
Black	15	22.39
Hispanic	1	1.49
Smoking Status		
Nonsmoking	44	65.67
Smoking	23	34.33
Hypertension		
No	45	67.16
Yes	22	32.84
No. of Co-existing Aneurysm(s)		
One	59	88.06
Two	7	10.45
Three	1	1.49
Hunt Hess Grade at Admission		
I	15	22.39
II	26	38.81
III	13	19.40
IV	13	19.40
Total	67	100.00

lostomies were performed in all cases intra-operatively and CSF was drained routinely for at least 72 hours postop until the cerebrospinal fluid was cleared of bloody drainage. All patients received a loading dose of 12 mg of Decadron in the emergency room followed by four mg every six hours. The patients also received Zantac 50 mg I.V. every eight hours. Dilantin or Phenobarb was administered to all patients initially at the time of admission to the intensive care unit and was continued for about 12 months postoperatively in most patients.

Following clipping of the aneurysm, volume expansion was obtained using a combination of Albumin and normal saline solution. The central venous pressure was maintained around the eight to ten range. TEDS anti-embolic stockings and compression boots were used for deep vein thrombosis prophylaxis. At the first

sign of cerebral vasospasm, Triple H Therapy (Hypervolemia, Hemodilution, Hypertension) was instituted.

Preoperative Assessment

Clinical assessment at admission included Hunt-Hess Grade, size, size and location of the coexisting aneurysms, and patient demographic data. Medical history data such as age, gender, race, smoking status, history of cardiovascular or kidney diseases, family history of aneurysm, etcetera, were also collected in order to justify the effect of these variables on the treatment outcomes.

Outcome Assessment

Treatment outcomes were assessed one year post-operatively based on return-to-work status or daily physical activity levels and self-care capacity. Patients were grouped into one of the following categories:

- Excellent (no limitation, return to work or previous lifestyle)
- Good (with some limitations, return to work)
- Fair (neurological deficit, able to return home but unable to work)
- Poor (significant permanent disability/nursing home), and
- Died.

Statistical Analysis

Descriptive statistics were used to describe the demographic and clinical characteristics of the patients and aneurysms. Chi-square tests, Pearson or Mantel-Haenszel test, were used to compare the outcomes among different patient groups. The significance level was set to 0.05. Data analysis was done using SAS-PC Version 6.11 (by SAS institute, Cary, NC).

RESULTS

Clinical Data

This series consisted of 50 (74.63 percent) females and 17 (25.37

percent) males with age ranging from 25 to 84 years (median equal to 55). A majority (76.12 percent) of the patients were white; 22.39 percent were black; and one (1.49 percent) was Hispanic. Twenty-three (34.33 percent) of the patients were smokers, 22 (32.84 percent) had hypertension. Demographic characteristics of the patients are presented in Table 1.

Diagnostic arteriogram was performed for all patients. Fifty-nine (88.06 percent) patients had a single aneurysm, seven (10.45 percent) had two and one (1.49 percent) had three aneurysms, presenting 76 aneurysms total. The size of the aneurysms in this series ranged from two mm to 25 mm in diameter. Twenty-seven were small (less than four mm), 43 were medium (4.1-ten mm), and six were large (10.1-25 mm). Of the 59 patients who had a single aneurysm, 23 had a small size aneurysm; 31 had a medium; and five had a large aneurysm. Of the seven patients who had two aneurysms, two patients had one small and one medium aneurysm, four patients had two medium ones, and one patient had a medium one and a large one. For the patient with three aneurysms, sizes were small for all three aneurysms.

Twenty-seven (35.53 percent) of the 76 aneurysms were located in the posterior communicating artery, 18 (23.68 percent) in the

Table 2. Aneurysm Characteristics

Variable	Number of Aneurysms	Percent (%)
Size		
Small (< 4 mm)	27	35.53
Medium (4.1-10 mm)	43	56.58
Large (10.1 - 25 mm)	6	7.89
Location		
Posterior Communicating Artery	27	35.53
Middle Cerebral Artery	18	23.68
Anterior Communicating Artery	13	17.11
Internal Carotid or Ophthalmic Artery	9	11.84
Anterior Choroidal Artery	4	5.26
Basilar Artery	2	2.63
Vertebral Artery	1	1.43
Intra-cavernous Artery	1	1.43
Peri-callosal Artery	1	1.43
Condition at Admission		
Ruptured	55	72.37
Not Ruptured	21	27.63
Total	76	100.00

Table 3. Hunt-Hess Grade at Admission and Treatment Outcomes

<u>Hunt-Hess Grade</u>	<u>Outcome (# of Patients)</u>		
	<u>Favorable</u>	<u>Unfavorable</u>	<u>Total</u>
1	13 (86.67%)	2 (13.33%)	15 (22.39%)
2	21 (80.77%)	5 (19.23%)	26 (38.81%)
3	5 (38.46%)	8 (61.54%)	13 (19.40%)
4	3 (23.08%)	10 (76.92%)	13 (19.40%)
Total	42 (62.69%)	25 (37.31%)	67 (100.0%)

$\chi^2_{MH} = 17.136, p < 0.001$

middle cerebral artery (Fig. 4A & B), 13 (17.11 percent) in the anterior cerebral-communicating artery complex (Fig. 3A & B), nine (11.84 percent) in the internal carotid (Fig. 1A, B, C, D) or ophthalmic artery, two (2.63 percent) in the basilar artery, and one of each in the vertebral, intra-cavernous (Fig. 2A & B), and peri-callosal artery. Fifty-five (72.37 percent) aneurysms were ruptured at the time of admission and 21 (27.63 percent) were not. Characteristics of the aneurysms are summarized in Table 2.

At admission, 55 patients had ruptured aneurysm(s). Of them, three (5.88 percent) had Hunt-Hess grade of I, 25 (49.02 percent) had grade II, 11 (21.57 percent) had grade III, and 12 (23.53 percent) had grade IV (Table 3). Clipping was performed for 55 patients with ruptured aneurysm(s) and 12 patients with unruptured aneurysm(s). Eleven (15.28 percent) patients had the procedure done within the same day of admission. All SAH patients in Hunt-Hess Grades I-III were clipped within 48 hours of admission. Twenty-seven SAH patients (49 percent) had ventriculostomy preoperatively while 11 patients with SAH (20 percent) had a VP shunt placed. Average hospital stay was 36 days ranging from six to 365 days.

Treatment Outcome

The treatment outcome at one year post-operatively was excellent for nine (13.4 percent) patients, good for 33 (49.2 percent), fair for 11 (16.4 percent) patients, poor for seven (10.4 percent) patients, and seven (10.4 percent) patients died.

Due to the small sample size in some outcome categories, treatment outcomes were classified, for analytical purpose, as favorable (excellent/good) and unfavorable (fair, poor, or died). Eleven of 12 patients (91.7 percent) with incidental aneurysms and 37 (74.5 percent) of the 55 patients with ruptured aneurysm(s) had a favorable outcome i.e. returned to work. However, if patients who were able to function at home with or without help but not working are considered, an overall 74.5 percent success rate is achieved.

Statistical comparison in treatment outcomes was made between patients with different age, genders, smoking status, history of hypertension, number of co-existing aneurysms, condition of the aneurysm (ruptured/not ruptured), size of ruptured aneurysm(s), location, Hunt-Hess grade at admission, and time from admission to clipping. Among these factors, only Hunt-Hess grade at admission seemed to be a significant factor in the treatment outcome based on the two-way Mantel-Haenszel Chi-Square test. As we can see from Table 3, the data indicated the better the Hunt-Hess grade at admission, the better the outcome was.

DISCUSSION

A direct causal relationship has not been established with any specific precipitating factor and aneurysmal rupture; however, consideration is given to hypertension, physical exertion, Valsalva maneuver, and sports and sexual activity at the time of the rupture.²

Unlike other forms of stroke, SAH increases linearly, not exponentially, with age. The incidence of SAH prior to the age of 20 years is less than one per 100,000.⁴

The patient with typical subarachnoid hemorrhage presents with a history of sudden or abrupt onset of headache, often described as the most severe headache in his life. Often, the headache is described as "bursting" or "explosive" and is associated with nausea and

vomiting, loss of contact with the environment or frank loss of consciousness, and/or seizure activity. After ictus, the patient is left with a severe headache and neck pain (nuchal rigidity), and often develops elevated temperature, irritability and restlessness, and photophobia.³

Patients with SAH have been noted to have remarkable abnormalities in cardiac rate and rhythm in up to 50 percent of the cases. The most common ECG abnormalities were T wave enlargement or inversion, prolongation of the QT interval, ST elevation or depression, prominent U waves. These abnormalities have generally been attributed to increased circulating levels of catecholamines and deranged autonomic control of the heart, resulting from SAH induced hypothalamic stimulation.⁴

The Glasgow Coma scale is one of the most commonly recognized tools to determine the level of consciousness using three major indicators: eye opening, motor response to painful stimuli, and verbal response. (Table 4) The most widely quoted grade scale for SAH is the Hunt and Hess classification. (Table 5)

Solomon and Correl¹⁵ recommended that any incidental aneurysm greater than three mm in

Table 4. Glasgow Coma Scale

GLASGOW COMA SCALE		
Eyes	Open	Spontaneously 4
		To verbal command 3
		To pain 2
		No response 1
Best motor response	To verbal command	Obeys 6
	To painful Stimulus	Localizes to pain 5
		Flexion - withdrawal 4
		Flexion - abnormal 3
		Extension (decerebrate) 2
		No response 1
Best verbal response		Oriented 5
		Disoriented 4
		Inappropriate words 3
		Incomprehensible 2
		No response 1

size should be considered for surgery. Schievink et al¹⁴ reported subarachnoid hemorrhage from previously unruptured four mm aneurysms in three patients. Other investigations have shown that incidental aneurysm less than ten mm could rupture and lesions

greater than five mm be treated.⁶ The incidence of aneurysmal subarachnoid hemorrhage in North America is 11-12/100,000. Approximately 25,000 new cases of ruptured aneurysms occur per year in the United States. Thirty-five percent die as a result of the initial hemorrhage leaving only 65 percent available for treatment. Mortality rates ranging from 40 percent to as high as 60 percent over the next several days to a month have been reported.¹² Rebleeding is a major cause of subsequent mortality and morbidity after the initial hemorrhage. The peak incidence of rebleeding is in the first 24 hours (4.1 percent) and at the end of seven days (16 percent). The mortality rate following rebleeding is very high (74 percent). Following the first six months the rebleeding rate drops to three percent per year with a mortality rate of 67 percent. Fischer et al clearly demonstrated the direct correlation between amount of blood on CT and the development of vasospasm and its related ischemia.⁵ To prevent rebleeding and remove blood products which could produce vasospasm and ischemic deficits, early operation has been accepted by the vast majority of neurosurgeons.^{7,8} Once the aneurysm is clipped, vasospasm can be treated and its ischemic effects controlled using hypertensive, hypervolemic hemodilution (Triple H) therapy¹¹. Nimodipine (60mg orally or sublingually) every four hours instituted after

Table 5. Hunt and Hess Classification

Grade	Description
1	Asymptomatic, or mild headache and slight nuchal rigidity
2	Cranial nerve palsy (e.g. III, VI) moderate to severe headache, nuchal rigidity
3	Mild focal deficit, lethargy, or confusion
4	Stupor, moderate to severe hemiparesis, early decerebrate rigidity
5	Deep coma, decerebrate rigidity, moribund appearance

subarachnoid hemorrhage and given for 21 days has shown to reduce the deleterious effects of vasospasms induced ischemic deficits¹.

In selected cases, angioplasty (balloon dilatation) may be beneficial to patients who have been refractory to conventional treatment. Local intra arterial (Papaverine) infusion has also been used to treat vasospasm.^{2,4,10} Fibrinolytic therapy using t-PA for prevention of vasospasm has been reported and a randomized multicenter study is ongoing. The routine use of anticonvulsants in the management of ruptured aneurysm is controversial. The incidence of delayed seizures is four percent. High risk factors include cerebral artery location, the presence of large intracerebral hematoma, shunt dependant hydrocephalus and vasospasm with infarction.⁹ Incidence of multiple aneurysm in angiographic studies averages about 12.7 percent and that of giant aneurysms is about five percent.¹⁶ Favorable results in the treatment of giant aneurysms have been obtained using afferent vessel occlusion or trapping with or without EC-IC (extracranial to intracranial bypass, balloon occlusion and intraluminal thrombosis either directly or stereotactically).^{3,13}

In conclusion, the results of this study compare favorably with previously published results. The data indicated that the better the Hunt-Hess grade at admission the better the outcome was ($p=0.001$). Incidental aneurysms were clipped with a very high success rate (91.7 percent). 37.14 percent of ruptured aneurysms in this series were less than four mm and another 55.71 percent were in the four to ten mm range suggesting that incidental aneurysms greater than four mm should not be treated as a benign lesion and should be treated by an experienced neurovascular team. Advancing age did not worsen the prognosis after SAH and therefore age should not be a contraindication for aggressive management.

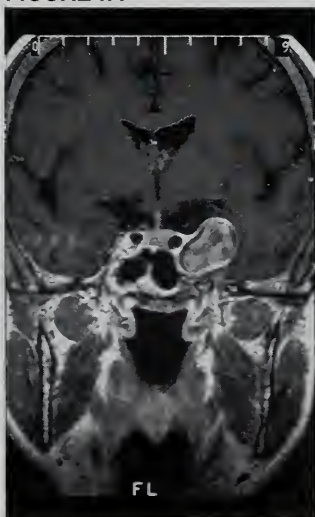
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FIGURES

FIGURE 1A



MRI (A) and pre-operating cerebral arteriogram (B) showing giant intra cavernous aneurysm of left internal carotid artery which was treated by EC-IC (extra cranial-intra cranial) bypass and gradual occlusion of internal carotid artery using Selverstone clamp.

FIGURE 1B



One year postop arteriogram shows total occlusion of the aneurysm and good blood flow in the left hemisphere via EC-IC bypass

FIGURE 1C

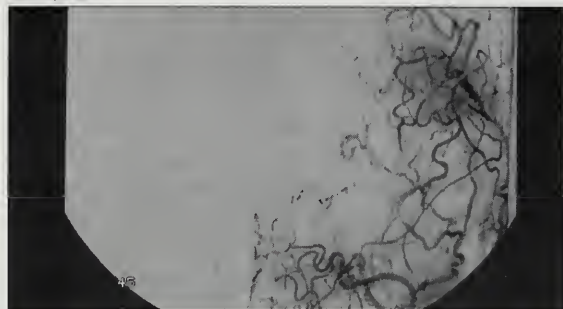
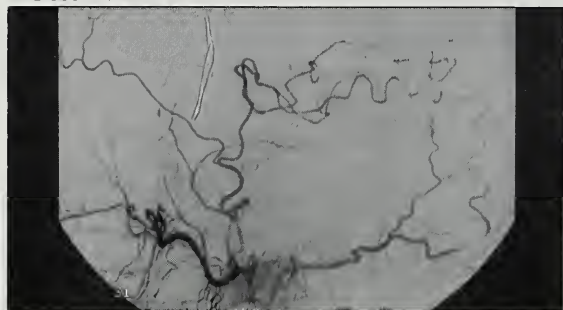


FIGURE 1D



Pre (A) and postop (B) cerebral arteriogram showing surgical obliteration of left anterior cerebral artery aneurysm.

FIGURE 3A

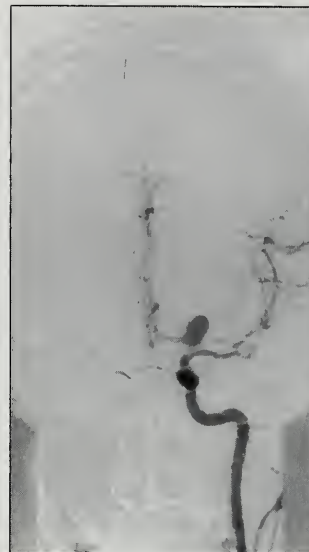
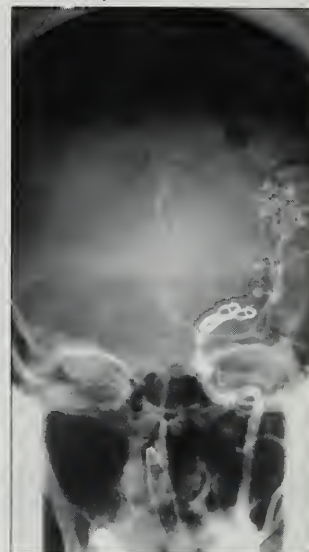


FIGURE 3B



This patient was found to have an incidental ventral vertebral aneurysm (A) which was clipped surgically (B) using skull based far lateral approach.

FIGURE 2A

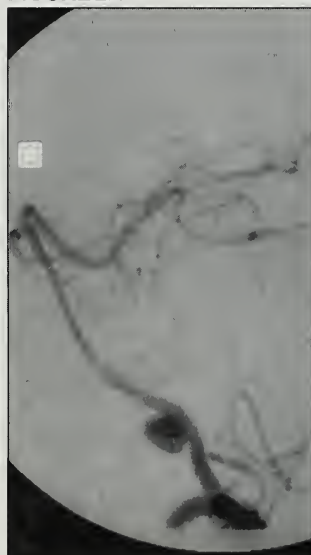
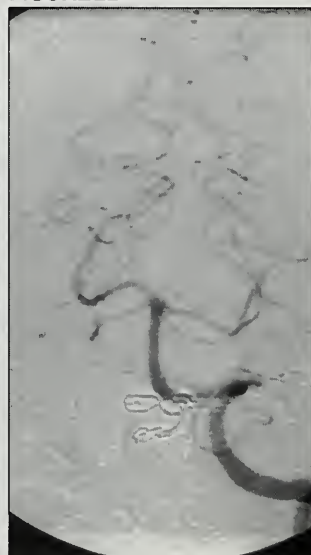


FIGURE 2B



Pre (A) and postop (B) cerebral arteriogram showing successful clipping of right middle cerebral artery bifurcation aneurysm.

FIGURE 4A

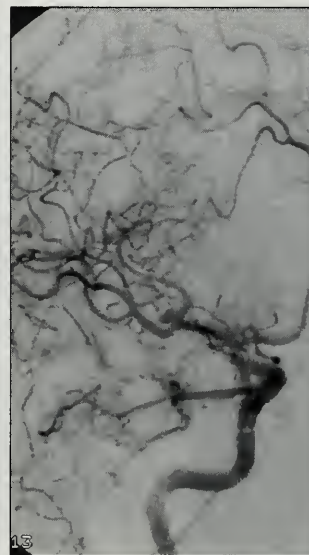
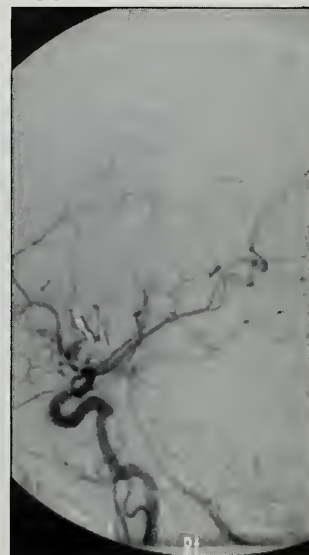


FIGURE 4B



Summary of the 1998 Annual Meeting's Scientific Sessions

E. Wayne Martz, M.D.

On Friday and Saturday, November 20 and 21, 1998, The Medical Society of Delaware conducted its annual meeting for the 209th time. There is only one other medical society in the United States that can beat that record. Things ran like clockwork, and you have read the details of the business activities in the *Delaware Medical Journal*. I have the distinct impression that the communication, understanding and cooperation between the northern and southern parts of the state are at an all time high, and the harmony and agreement in the House of Delegates was noteworthy. The very important decision to continue our unification with the AMA (symbolically, with our profession nationwide) for another three years, was made with only two dissenting votes, and the decision to assess ourselves \$50 this year to restore our operating reserve fund (depleted by the start-up costs of our new enterprises) and to increase our dues by \$25 per year, was made with no (audible)

dissenting votes. This still leaves us with the fourth lowest dues in the nation.

I am privileged to report to you on Saturday's activities, specifically the Prayer Breakfast, the Scientific Sessions and the Awards Luncheon. I leave the Dinner Dance to someone else.

The Prayer Breakfast was a little smaller than it has been in recent years, but still attracted about 50 people. Although the audience was of several different religious backgrounds, the program was straight traditional Christian (Episcopal), and featured Mr. Wilson Somers, Music Director of the Tatnall School, describing his ten year production of the Mass for the Homeless. This has been successfully conducted at the Wilmington Opera House and elsewhere, raising funds for those organizations in New Castle County that care for the homeless. This is a truly remarkable musical work including the traditional five major parts of the Mass: the Kyrie (Lord have mercy), the Gloria (In excelsis Deo), the Credo (Nicene or Apostles' Creed), the Sanctus (holy, holy, holy Lord) and the Agnus Dei (lamb of God). We all learned something and came

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away refreshed. We all look forward to another religion-oriented presentation next year.

The Planning Committee, headed by David Biggs, M.D. and David Grubbs, M.D., gave us something new this year, one and a half hours of workshops, instead of taking the entire morning for lectures. The four workshops offered were

Office Dermatology, EKG Interpretation, Cancer Screening and Joint Aspiration and Injection. I was only able to attend three of the four, but they were all well attended (25 plus or minus). They varied considerably in format and facilities, but all seemed successful in providing a welcome opportunity for practical individualized learning.

Moving End-of-Life Issues Into Mainstream Medicine An Historical Perspective

The scientific lectures were introduced by David Biggs, M.D., and started off with an Historical Perspective by Joseph F. Fennelly M.D., an Internist in Madison, NJ, who spoke on Moving End-of-Life Issues into Main Stream Medicine. In 1975-76, Dr. Fennelly, Chairman of the Humanities Committee, moved from spokesman for the Morris County Medical Society to physician for Karen Ann Quinlan and her family. This was the case of a 19 year old woman in a persistent vegetative state secondary to asphyxia. Her father won permission to have her removed from the ventilator. This was a landmark case that defined the issues and effectively molded public opinion on death and dying, putting the entire subject of end-of-life decisions into a new perspective. It has opened up a host of issues which people had not thought about before, including the concept of brain death, the option of organ donation, advanced directives, "do not resuscitate" orders, and a cascade of derivatives from these.

In dealing with a very serious topic, Dr. Fennelly got his meaning across with humorous phrases and one-liner darts that got right to the heart of the matter. "Doctors are not very good at managing death." "For some doctors plain English is a second language," referring to our tendency to hide behind big words the patient does not understand. He referred to "Professors who have never made a house call, never dealt with ambiguity and uncertainty" and on a note of hyperbole "Two decade ago, a child died (at CHOP) without resuscitation." We must realize that "metabolism" is not human life. However, the doctor has a triple function: "Which *doctor* writes the order, *wish doctor* rights the prob-

lem, and *witch doctor* performs the rites of healing. Whether or not we like it, the public expects doctors to make the tough decisions subsumed under this triple function." "The assumption of judging, the power of deciding, MEDICINE is stuck with it." We are not only the gate keepers for referrals, but also "maybe at the Pearly Gates." This requires that we know our patients as people, and not just as illnesses, and for this there is nothing better than the house call. It is not for everyone, but for those special cases, it is a must. "It is symbolic " We may not like the responsibility for those end-of-life decisions, but often the family and loved ones are totally unable to make them, and it is better for us to make them than the courts, the hospital administrator or academia. Hospice and home care are not the complete answer, though palliative care is a must. We are born dying and are rehabilitated daily. Palliative care comes closest to the rehabilitation model. "We must go beyond the tendency to fix medicine as if it were separate pieces of a quilt. To create 'seamless' tapestry of caring, medicine needs the alchemy of new ritual translated into standard operating procedures. Care that will replace the negative language of 'do not resuscitate' with the positive actions of caring subsumed in appropriate comprehensive compassionate care." Do not turn off the machines or pull the plug. When all hope is gone, turn down the oxygen flow. Reduce the respiratory rate and start the morphine drip.

Karen Ann Quinlan stood for a changing paradigm, a different way of looking at death and dying. It is a fitting legacy for all who participated in her care.

Potential Impact of Cloning on Human Infertility and Gene Therapy

The second speaker of the morning was Paul G. Mc Donough, M.D. A Jefferson graduate, Dr. Mc Donough initially trained in Philadelphia, but has spent his professional career at Medical College of Georgia in Augusta, in Reproductive Endocrinology. Dr. Mc Donough addressed the question "Where are we going in clinical medicine?" Since genetics is proving to be a factor in nearly all human illness, it seemed appropriate that he answered this in terms of genetics.

Though Gregor Mendel did his work in the 1850s, it was 100 years before Watson and Crick described the double helix of DNA. With approximately three billion pairs of Guanine-Cytosine or Adenine-Thymine it seemed virtually impossible to unravel this chemically until restriction enzymes capable of cutting these ribbons into smaller pieces, which could then be recombined, were developed. In families with known hereditary disorders (e.g. Huntington's) it was noted that some fragment markers persistently segregated to persons with the specific disorder. It was not necessary to know all the biochemistry. That fragment was a marker, and finding it established the diagnosis, pre-clinical and pre-symptom.

In 1985, Dr. Mullis developed the technique of heating DNA to split the strands, which then reunite on cooling (recombinant). By adding pieces of DNA with known characteristics to the mix as a primer, the amino acids will copy it in both directions in a polymerase chain reaction. Thus, one can amplify the gene into literally millions of copies by heating and cooling, making sufficient product for analysis. This product can be compared with other fragments by gel

electrophoresis. Using these techniques, the detailed mapping of the human genome was begun in 1990 and is expected to be completed in 2005. Many of the steps in the process can be automated, and with computerization and pattern recognition, attempts are being made to put this to commercial and therapeutic use.

Genes can be injected into embryos. One such effort was described using mouse embryos, injecting a growth hormone gene tied to a promoter responsive to certain catamines. When these were subsequently fed to the mice, there was a growth hormone response. Since 1986 work has been done removing the nucleus from oocytes and inserting new genetic material. Multiple new embryos can be produced from the original one. In the case of Dolly, the cloned sheep which got so much media attention, they started with a somatic cell and added a granulosa cell nucleus. The new embryonic or "stem" cells can be cultured and will reproduce. The problem is how to regulate them so they can be differentiated into cardiac, hepatic or neural cells that one happens to need, and add self-recognition genes to avoid rejection.

At the present time, cloning from (human) somatic cells is forbidden in the United States, and the Federal government will not support it from embryonic cells. Safety and political considerations make progress complex and difficult, at least in the United States, though not necessarily in other countries.

Dr. Mc Donough's parting words - "You will eat a clone long before you will ever shake hands with one."

Congenital Heart Disease at the Turn of the Century

The third scientific paper was presented at the luncheon by William I. Norwood, MD, the internationally acclaimed Chief of Cardiothoracic Surgery at the Alfred I. DuPont Hospital for Children. He protested several times that he is

"a surgeon - not a speaker" but nevertheless presented a sparkling and exciting talk. He entitled it "A stroll through congenital heart disease," but I should say we proceeded at more of a gallop.

Dr. Norwood estimated that there are 26,000 newborns in the United States annually who need surgical correction of congenital heart defects. We used to wait until they were old enough for the heart and vessels to be handled readily, but there is a degree of failure involved in that, and current thinking is to correct them as early as possible, sometimes at two to three months of age. There are about 60 well defined anomalies, but the vast bulk of these are of one of six types. Some of these six are fairly easily corrected, but the most difficult and long considered impossible, are those involving atresia of one of the great vessels associated with hypoplasia of the corresponding ventricle. These infants are fine during intrauterine life, and the defect is unsuspected, but it quickly becomes evident when the infant starts to breathe. So hopeless did this condition seem that some advocated heart transplant (Bailey, Loma Linda). However, this only exchanged a heart problem for an immunologic problem requiring lifelong attention, and additionally there were far too few suitable hearts available.

Early attempts at correction of congenital defects had as their goal the approximation of normal cardiac anatomy. A different way of looking at the problem was promulgated by a French doctor (Fontan) working with hypoplastic right ventricles. Drs. Norwood, Fontan and others are now more interested in approximating normal physiology, regardless of the anatomy. The initial physiologic crisis is brought on by closure of the patent ductus arteriosus. Since this is related to prostaglandins, it is possible to buy a little time (measured in months). Another problem is the underdeveloped pulmonary vasculature, whose development parallels the closure of the ductus. The pulmonary circulation is normally a low pressure system, and once the pulmonary circuit is established a right ventricle is almost redundant. The drop in pulmo-

nary resistance is the key. The inferior and superior venae cavae can be made to feed directly into the pulmonary artery and its branches. This permits the use of the right ventricle for the systemic circulation. It is axiomatic that either ventricle can do the work of the other. At first the correction was attempted using the patent ductus arteriosus, but this created problems with the coronary circulation, which you recall originates at the root of the aorta. Therefore, the aorta is now connected directly to the ventricle and the ductus is closed. It reduces the mortality considerably if this can be done in one stage. That depends on the skill and efficiency of the surgical team.

There is a tendency for the post-operative course to be stormy, largely because the cardiorespiratory physiology of the newborn is quite different from that of an adult. For example, giving oxygen causes reflex changes in the pulmonary vascular resistance, which can lead to circulatory collapse. Critical is the ratio of the pulmonary vascular resistance to the systemic vascular resistance. They are interdependent, and thus the pO_2 and the pCO_2 are important. Adding CO_2 to the inspired gas limits the pulmonary blood flow and avoids the hypoventilatory risks. We still need more knowledge and understanding of these phenomena, but there are other needs as well. We need new pharmaceuticals to handle these reflex changes. Prenatal diagnosis would be helpful. Genetic manipulation to avoid these maldevelopments seems pretty much out of the question, since they originate in the first two months of embryonic life, but there might be factors we are currently unaware of which could be added or removed.

Dr. Norwood's final words - "Virtually every malformation is now reparable in the first 12-18 months of life. This allows the family to get back to normal living."

Stroke: No More Diagnose and Adios

Lee P. Dresser, M.D.

Neurology has long suffered from the reputation of having a paucity of therapeutic options. Neurologists have been perceived as possessing a large book of diagnoses and a quite small book of treatment. "Diagnose and adios" was the *modus operandi* attributed to neurology. Fortunately, for patients suffering from diseases of the nervous system, and neurologists, this situation has significantly improved during the the 1990s, declared by President George Bush in 1989 to be "The Decade of the Brain." We have seen an explosion in the number of antiepileptic medications available for patients with intractable epilepsy. There have been several new medications approved for the treatment of Parkinson's disease, as well as an increased interest in surgical therapy for this affliction. Medical treatment of the cognitive decline of Alzheimer's disease is available for the first time, and we now possess

new and very effective medical therapy specifically designed to treat migraine.

In no other area of neurological disease has the improvement in therapy been more welcome than for patients suffering strokes. Over 700,000 Americans experience strokes each year. The cost to society in medical care and lost productivity is estimated to exceed \$40 billion per year. Stroke is the number one cause of disability in this country. With the publication of the National Institute for the study of Neurological Disorders and Stroke (NINDS) study in 1995, we learned that the thrombolytic agent tissue plasminogen activator (TPA) was an effective therapy for acute cerebral infarction.¹ This represented the first therapy actually shown to decrease the morbidity associated with cerebral infarction. While a more recent study employing TPA did not show as significant a benefit,² TPA therapy still represents a major step forward in the treatment of stroke.

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Although TPA has been approved for the use of acute cerebral infarction since June 1996, it has been very infrequently utilized.³ This is due to a number of factors. The lack of urgency with which stroke has traditionally been treated and the patient's delay in seeking medical evaluation for symptoms of cerebral ischemia are probably most significant. The NINDS study¹ and a post hoc analysis of the European Cooperative Acute Stroke Study I (ECASS I)⁴ showed that for TPA to be used safely and effectively it must be administered within three hours of the onset of stroke symptoms. Unfortunately, a large percentage of the general population is not familiar with these symptoms, their significance, or the importance of seeking emergency medical evaluation. Once these stroke patients present to the emergency room or physician's office, the mechanism to very rapidly evaluate them has not traditionally been available. The three hour time limit will, therefore, frequently expire before the infusion of TPA can be started. Patients need to be screened for exclusion criteria before TPA can be utilized, similar to patients with acute myocardial infarction being considered for thrombolytic therapy. They must also undergo cranial computerized tomography to exclude intracranial hemorrhage and informed consent needs to be obtained. To help increase the utilization of TPA, St. Francis Hospital in Wilmington has developed guidelines, pathways, pre-printed order sheets and consent forms so that eligible stroke patients may be rapidly identified, evaluated and, if appropriate, treated with this thrombolytic agent. The development of a TPA protocol was part of the effort of a Brain Attack Committee to improve the treatment of stroke and transient ischemic attack patients at St. Francis. This effort has included the plan to have a dedicated stroke unit with nurses specially trained to evaluate and treat brain attack patients. Such units have demonstrated a reduction in morbidity and increased efficiency in the management of stroke patients.⁵ The development of a TPA protocol is also under consideration at the Christiana Care hospitals in Wilmington and Newark.

Along with the increased efficiency and urgency of patient evaluation in the hospital, an effort to educate the general public about the signs and symptoms of stroke is crucial if patients are to be brought to medical attention in a timely fashion. The replacement of the term "stroke" with "brain attack" is part of the effort to raise the general awareness that this condition needs to be treated as an emergency. Even more important than emergency therapy of brain attack is its prevention by recognizing and treating modifiable risk factors. Hypertension and atrial fibrillation must be screened for and treated appropriately. The importance of smoking cessation and strategies to help discontinue smoking should be discussed with patients. Optimal management of diabetes mellitus will also help decrease stroke incidence, as may the treatment of hyperlipidemia.

The past decade has seen the development and widespread utilization of more powerful tools to accurately diagnose brain attack and its cause. Magnetic resonance (MR) imaging techniques have been refined and MR angiography has allowed visualization of the cerebral circulation without the risks of conventional angiography. MR diffusion and perfusion techniques will allow physicians to more rapidly detect the location and severity of ischemic injury within the brain. This will help better determine which patients may benefit from therapies such as TPA. Transesophageal echocardiography has greatly increased the detection of cardiac embolic sources and allowed more appropriate treatment of brain attack patients.

With the rapidly expanding therapeutic armamentarium and the more complicated diagnostic technology, it is difficult to stay abreast of what is the optimal way to prevent and treat brain attacks. With this in mind, the recently formed Delaware Stroke Initiative, a group of local business and health care professionals, have organized a Stroke Symposium on March 20, 1999. This will be a forum where health care

providers can learn more about the state of the art management of brain attack from a panel of regional and national experts. The Delaware Stroke Initiative is also involved with efforts to increase public awareness of the signs and symptoms of stroke and the need for emergency evaluation. The symposium will also feature a special luncheon speaker. It is estimated that more than 10,000 residents of Delaware are at high risk to suffer a stroke. Increased efforts to prevent these disabling and deadly attacks and improve victims chances of recovering good neurological functioning will be very valuable. This symposium promises to be a very educational and enjoyable event and will hopefully contribute to improved care of brain attack patients. I strongly encourage all Delaware health care providers to make an effort to attend.

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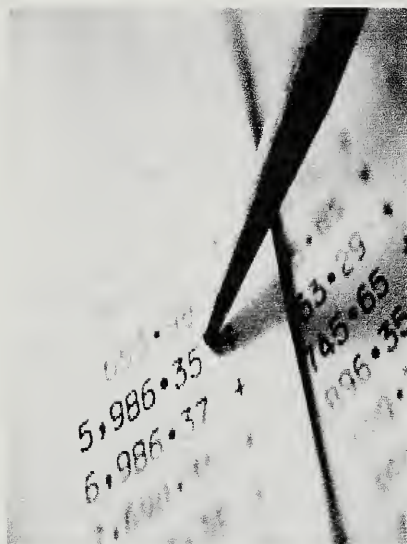
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Stroke

Charles L. Reese IV, M.D.

To the Editor:

In this issue of DMJ, Dr. Dresser presents an intriguing view into the brave new world of neurologic therapeutics, focusing primarily on the acute treatment of stroke, or "brain attack." While his vision is justifiably optimistic, our own experience in this area has taught us a few practical lessons which may be of interest.

Emergency physicians (EMDs) dearly love acute interventions, especially those which can cause a dramatic clinical improvement; witness, for instance, the enthusiasm with which we embraced lytic therapy for acute myocardial infarction (AMI) in the late 1980s. With the same optimism, from the Fall of 1996 to the Spring of 1997, we participated in the ATLANTIS study

(Alteplase Thrombolysis for Acute Noninterventional Therapy in Ischemic Stroke). As part of that research protocol, we created the system necessary to give lytic agents in a timely fashion, and we saw several exciting "saves" along the way. Yet, when the study was over we saw a spontaneous turn away from the stroke protocol; EMDs, consultants and the medical community in general seemed to lose interest. Why did this occur?

Our first clue lies in the national perspective, because opinion leaders in emergency medicine are still openly skeptical about lytic therapy for stroke. One in particular notes that of the five large, international studies in this area, only one has shown even modest benefit;⁵ the others were neutral to frankly negative.^{3,4,6,7} In his opinion, sufficient benefit has simply not been demonstrated. This is especially true given the resource commitment necessary to administer the drugs properly.

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While the administration of lytics for AMI can be reliably accomplished on the basis of an EKG and EMD opinion, stroke patients require a much more complex response. In addition to the usual pre-hospital, triage, pharmacy, and other elements, a CT scan must be done and promptly interpreted. In

addition, most EMDs require that a neurologist see the patient before proceeding. For peripheral lytics to be effective, all of this must be done within three hours of symptom onset. Maintaining this system in a state of optimal readiness can represent a real and ongoing challenge to all involved, especially when it is activated infrequently.

Christiana Care is one of the busiest facilities in the nation, with a yearly census of 118,000. Each month, we admit 40-50 patients with stroke (DRG=014). Eligibility rates from ATLANTIS¹ and NINDS ranged from 2.8 to 3.6 percent; thus at most we might be able to use lytic therapy for two patients per month. With so few eligible patients amidst so many "false alarms," the staff loses focus and the system becomes rusty, leading to a semi-inevitable degradation in performance and enthusiasm.

Finally, from a purely behavioral viewpoint, using lytic therapy in this setting can be a real source of anxiety for the clinician. Somehow, using lytics for stroke seems more dangerous than for AMI, probably because the complication of cerebral hemorrhage is so catastrophic and hard to treat. Indeed, some degree of bleeding (albeit minor) probably occurs much more frequently than is nationally reported. We remember one case where the patient, an ideal candidate (young, generally healthy, timing well within limits, dense hemiplegia) was given alteplase but 30 minutes later made a rapid descent into coma. A repeat CT scan actually showed no bleed, and to our amazement he later awoke without deficit — a true save, but one which required a "high degree of intestinal fortitude."

Thus, the use of peripheral lytic therapy for stroke is problematic. At the same time, we must emphasize that it does indeed have its place in the armamentarium. But because lytic

therapy is so inapplicable to so many patients — and because its benefits are so tenuously defined — other options must be found.

To meet this need, there are a number of fascinating possibilities hovering at the medical event horizon. Last month, we spoke with a neuroradiologist who had recently finished his training at a major academic center in Boston. His description of their system is instructive and holds, I believe, the core of a vision for our own future.

In Boston, the public appears to be more aware of health questions and tends to call Emergency Medical Services (EMS) early for acute CNS problems. EMS, in turn, is highly aware of the time factor involved. The problem of insufficient numbers is solved by referral of all potential patients to a tertiary center. At that center, important community resources (highest tech imaging, subspecialty physicians, etc.) are concentrated for 24 hour

availability, and because the center is involved in so many studies, lytic therapy given by peripheral vein may be only one of many therapeutic options. For instance, though still experimental, intra-arterial urokinase has been reported to allow reduced morbidity within an increased (six hour) window of opportunity. For patients with subarachnoid hemorrhage, interventional techniques can be dramatically effective. In the subacute phase, neuroprotective and other agents are becoming increasingly important, as is the use of dedicated, pathway driven stroke units.

The lesson is clear: a quantum change has already occurred, and its spread to Delaware is inevitable. However, the transition into this new state will not be easy, nor will the path forward be obvious.

As we move forward, therapeutic options will proliferate, just as those for acute myocardial infarction have multiplied during the past decade. Virtually all these options (actual or imagined) are highly resource intensive, and a variety of interesting cost/benefit questions will be sure to arise. Further, a major cultural change within the medical community will be required,

and the resulting angst will be significant (will we ever see, for instance, an “interventional neurologist”?).

Nevertheless, our community sorely needs a well thought out, evidence-based system which effectively deals with “brain attack” from the moment its first symptoms arise. The key elements are increased public awareness, reliable triage to an appropriate tertiary center, and prompt, pathway driven therapy using state of the art technology and personnel. The public health opportunities are extraordinary and must be embraced by all interested parties.

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Christos Stavros Papastavros, M.D.

Thomas Fiss, M.D.

*"Dr. Christos Stavros Papastavros, 78, a Wilmington radiologist who founded Delaware's largest independent X-ray practice, died Friday of head injuries in Christiana Hospital. He was struck by a motor bike in Athens, Greece, Jan. 29 and was flown to Christiana Hospital Feb. 8" - The News Journal * Monday, Feb. 16, 1998*

He was, by any criteria, one of the most amazing men I ever met. His biographical sketch is easy enough. He was born the youngest of seven children in the village of Terpsithea, Greece, on May 19, 1919. He attended village schools and eventually, entered the University of Athens where he received his M.D. degree in 1944. He served in the Greek army during the second World War and the Greek Revolution until 1949. A year later, he arrived in the United States. He completed a residency in radiology at the Delaware Hospital in 1954. He then worked at the Memorial Hospital until 1958 when he started his own practice. There, he became known affectionately as "Dr. Chris" to his admiring staff. The practice became one of the largest and most successful of its kind anywhere. In his obituary, the local newspaper correctly called him a pioneer of radiology. While others quibbled about the cost effectiveness and the practicality of the new technology in commu-

nity medicine, he was the first to introduce CT scanning, MRI, and SPECT imaging to the First State. These modalities are now considered commonplace and essential. When he practiced radiology, he was easily the best known radiologist in the state. Yet, this became so because he was a combination of old world charm and new world industry. It was a melancholy day when they wheeled Dr. Chris' stretcher over the Wilmington tarmac, yet I felt happy that he had come home. When they sang *America* at his funeral, I wept.

The office was really based on a few simple principles. You would learn to "serve the patient" and to have a work ethic, even if this meant remedial instruction from the founder himself. The office would be spotless, no matter who had to remove the spots. The technologist would learn the proper pronunciation of the patients' last name. If the patient was not young enough to be accompanied to the office by an adult, the patient would be addressed by Mr., Mrs. or Miss (the term Ms. had not yet been invented). If the patient was having

Thomas Fiss, M.D., is a radiologist in Wilmington, Delaware.

an upper G.I. or other study, which directly involved the radiologist, the technologist would introduce the patient to the radiologist so that the radiologist could properly greet the patient. A report would be dictated and typed on each x-ray performed that day. It would then be mailed or hand-delivered (sometimes by a radiologist) to the referring physician's office, the same day.

On the morning of a near blizzard, Dr. Chris, as was his custom, arrived at the office early. Having surveyed the situation, he decided to close the office and the personnel were advised of this decision. One technologist recalls that she and her husband were shoveling out the car at the time. They retreated to the warmth of their home when they got the message. However, a short time later, Dr. Chris called the technologist back and advised her that her presence was needed at the office. This second communication was received with great chagrin by the husband, who was doing most of the shoveling. It seems that an elderly gentleman had risen at 4:00 a.m. that morning to put chains on his car so that he

could arrive at the appointed time for his barium enema. When the technologist arrived at the office, she and Dr. Chris performed the barium enema and the patient was served.

In an endeavor that demanded both the practice of medicine and the vigors of business, he excelled at both. It would have been easy for a person in Dr. Chris' position not to keep current of the new modalities and to assign that task to the younger

associates. However, he knew and did all the things which he introduced to Delaware. He remained a modern radiologist until the day he retired in 1987. He was a superstar before the word was coined. You were not only in awe of his performance but recognized that he elevated yours as well. In those days, there was not a single person, from the recent high school graduate hired

to do filing, to the most senior radiologist, who was not better because he was there.

I suspect he came to this land to better himself but in doing so, he helped countless others do the same. He was a generous man, a patron of the arts, and a charitable force in his community.

He was a dream catcher. Everyone who worked in the office during those years, dreamed just a little bit bigger. From the young man, with an associate degree, who dreamed of owning his own boat, to the single mother who dreamed of owning her own home, he personally intervened to make those dreams a reality. He served tirelessly, the patient who dreamed of being treated as an individual, and the

physician who hoped for help. Everyone who had a dream had a better chance of having it fulfilled because he was there. People understood this and would circulate themselves. Some would start as a clerk at the front desk, realize how good a place it was, quit so that they could train to be a technologist, and then return as one.

He could be fussy, demanding and even outrageous. All perspective employees were asked "do



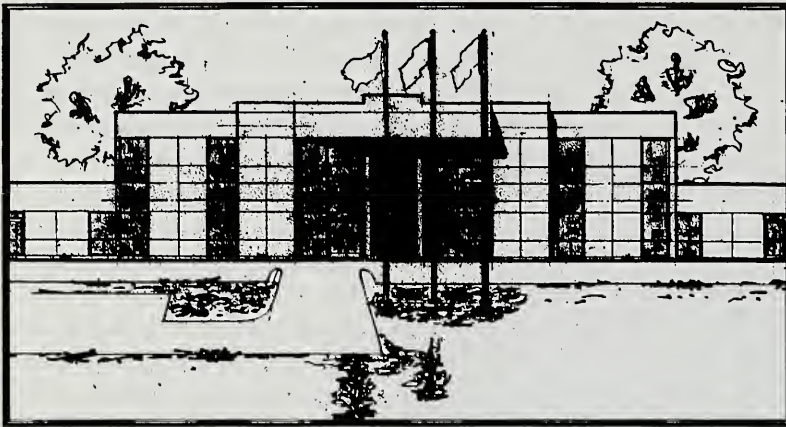
you smoke?" In the early days, if someone would call in sick, he would go to their house to investigate. On more than one occasion, he would tell the person that they were not sick enough to stay home and to get dressed. That person would return to the office with Dr. Chris.

Later on, when the office became busier, he would call the "sick" person several times the day of their absence to make sure that they stayed home the entire day. When the employee answered the telephone, he would just hang up. Snow was usually considered no excuse. If you did not come to him, he would go to you. At one time, the practice had a four-wheel drive vehicle for this purpose. Personal hygiene was important. Arun in a young lady's stocking was not to be tolerated. After receiving a lecture about this, the technologist was given his personal credit card with instructions to go to the old John Wanamaker's store and "get yourself some new hose."

He arrived early at the office each day and would inspect it for cleanliness. Although it had been cleaned the night before, it usually did not meet his standards. He would then get the technolo-

gists who arrived early that day to prepare the barium mixtures, to finish the job. They were not particularly happy to be cleaning toilets, scrubbing floors, and washing the walls. While doing this, they reminded each other that one of the reasons they became technologists, was precisely to avoid the type of work that they were now found themselves doing. However, these same technologists also remember that when they worked late, he would give them enough money so that they would not have to prepare dinner for their families that night but could buy something on the way home instead. They also remember that when they and their families had saved for that big vacation, he would give them something extra so that they could enjoy it more. The constant theme of any old "Dr. Chris story" is that "he made me better." Each individual had a profound understanding of that and loved him for it.

He is survived by his wife of forty-four years, Elizabeth Burr Papastavros, his son, David, his daughter, Christina Papastavros Fay, his brother, George, his sister, Lambrini Papapustolu, and four beautiful grandchildren.



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Looking Backward on Two Lives in Medicine

David Platt, M.D.

Whatever Ethel and I have done, we have done together. Ethel has been my girlfriend, my wife of over fifty-eight years, my partner in medical practice, my adviser, and my best friend always.

We both went to the University of Pennsylvania as undergraduates for four years, overlapping three of those years, but our paths did not cross there. We met at a medical students' meeting at the end of my third year at University of Pennsylvania Medical School, and Ethel's second year at Woman's Medical College of Pennsylvania. One year later we were married. Then I started my internship in 1940 at Wilmington General Hospital, while Ethel did her senior year at medical school. She applied for internship at the Wilmington hospitals, but was told they had no housing facilities for female interns.

David Platt, M.D., is a retired family practitioner and a member of the Medical Society of Delaware.

We searched for a location to start our practice. We both came from working class family backgrounds, and elected to position the office where we could readily serve working class people. We found that site, and on completion of the internship I opened our office at the corner of Fourth and Franklin Streets in Wilmington, while Ethel served her internship at the Frankford Hospital in Philadelphia.

I expected to be busy, but spent the first week sitting in the office seeing an occasional patient, but mostly reading journals. I then phoned the Physicians' Exchange and every primary care physician I had met in my internship, with an offer to make all their surplus house calls, whether by day or by night, whether pay or no pay. From then on I was busy.

Before that year was over, World War II was on, and I closed the office to spend two years in

Texas and two years in the islands of the South Pacific as a doctor in a field medical unit.

At the completion of her internship, Ethel reopened the office and soon was very busy, with office hours, innumerable house calls, hospital rounds, and free clinics for both the hospitals and the State Board of Public Health.

Then 1946 came and we were happily reunited. We finally began practicing together, and it was a busy joy. In time, we treated generations of families and delivered thousands of babies. Our patients were our friends and were part of our every day lives. We were invited to the life functions of their families. Our fees were modest. Office visits were \$1, home visits \$2, complete obstetric care \$50. Through the years, with inflation, the fees were very gradually increased. House calls were made frequently every day, and often at night. They were never screened, and the indication for a house call was that the patient thought it was needed. When Medicare came alive, we of course participated immediately. When Medicaid became available, it was a wondrous event for many of our patients. We made the Medicaid patients feel wanted, and they sent us their friends. Soon, 40 percent of our practice consisted of the care of Medicaid patients.

When our son was born, we were able to manage, because we lived on the second and third floors over the office, and I usually made all the house calls and hospital rounds to permit Ethel to spend more time with Richard. We had a round-the-clock live-in housekeeper, which

solved the problem of the occasional emergency or two ladies delivering at the same time, which required both of us to be away. In time, Dr. Leo Sherman joined us, then Dr. Barrie Weisman, Dr. Edward Sobel, and Dr. Mercedes Narvaez. With a group of six, our lives became less hectic, but no less interesting and fulfilling.

When the Delaware Academy of Family Physicians was organized, we became very active with it, because we believed in its two goals: continuing medical education of the family physician and service to the community at large.

Finally, in 1989, the time came for us to retire, 49 and 48 years after medical school graduation. We were fortunate that we have found medically related volunteer work to do, especially since it centers on trying to help young students avoid the hazards of drug and alcohol abuse, teen pregnancy, and the other temptations facing today's students.

We are asked whether we think managed care will ruin the future of medical practice. We think very strongly that it will not. We hope that the bond of the patient-doctor relationship will remain strong enough to prevail. Although insurance companies at this moment have power and control, we believe that forces already at work, such as not-for-profit HMOs, and integrated physician-hospital-staff organizations, will wrest control from the for-profit insurance companies. We are happy to encourage any young man or woman interested in a life in medicine, to go to it. We can think of no better way to spend one's life.

UPCOMING CONFERENCE

TITLE: Role of Families in Preventing and Adapting to HIV/AIDS

DATE: July 21-23, 1999

WHERE: The Warwick Hotel, Philadelphia, PA

Sponsored by the Office of AIDS Research, National Institute of Mental Health, NIH, and the University of Pennsylvania. Conference objectives include:

- Family processes associated with the epidemiology and high risk behaviors of family members
- Family configuration and functioning as predictors of adaptation at different stages of HIV/AIDS
- Stress and coping strategies mobilized by families infected and affected by HIV and AIDS
- Family issues of multiple losses, death, bereavement, child custody, and permanency planning
- Models for mental health services for families with a life-threatening disease
- Strategies for analyzing family data
- Attract more family researchers to AIDS research
- Generate new ideas and collaborations
- Develop research initiatives for HIV/AIDS family-oriented research

For more information, or to register, please contact Robin Toliver at 301-577-0244 or e-mail (robin@blseamon.com). Registration must be received no later than May 28, 1999.

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The rights to this top level domain have been acquired by Florida-based Domain Name Trust, Inc. Therefore, to use .md, a physician must register with Domain Name Trust, Inc. and pay a yearly fee of \$299. If you are interested, the address to register is www.register.md.

THE JAMA CONTROVERSY - AMA STANCE

The following are excerpts from a letter received by the Medical Society of Delaware from the AMA's E. Ratcliffe Anderson, Jr., M.D.

...Dr. Lundberg, through his recent actions, has threatened the historic tradition and integrity of the *Journal of the American Medical Association* by inappropriately and inexcusably interjecting JAMA into a major political debate that has nothing to do with science or medicine...

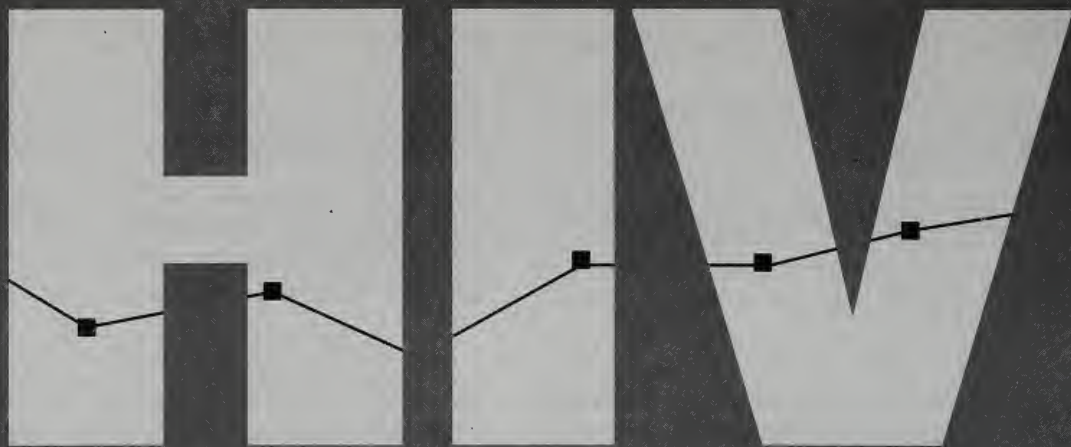
Here are the facts: ... in the January 20 issue, JAMA published an article headlined, "Would You Say You 'Had Sex' If ...?" The article presents the result of a 1991 survey of college students by the famous Kinsey Institute. The eight-year-old survey had found that 60 percent of those asked believed they had not "had sex" if the most intimate behavior engaged in was oral-genital contact. Publishing this survey this way at this time imposes JAMA into the highly-charged political debate surrounding the impeachment proceedings now underway in the U.S. Senate.

It is important to me that each of you understand just how strongly I believe that it is not the AMA's business - nor is it JAMA's business - to interject itself into political controversy of this kind...

The AMA has a responsibility to the medical profession, our patients and to the country to ensure that the editorial decisions of the world's most trusted medical journal are based on science and the highest standards of medical journalism.

There is no question that over many of the past several years Dr. Lundberg and his fine staff - always working with complete editorial independence - have advanced the stature of JAMA. Over time, however, I have lost confidence and trust in Dr. Lundberg's ability to preserve that high level of credibility and integrity.

Trust and integrity are at the very heart of the work we do together at the AMA and throughout the Federation. Nothing is more important. If we don't get this right, we don't get anything else right. That's why this tough decision was necessary...



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Proceedings of the 1998 House of Delegates Part II

The complete report of the Proceedings of the 1998 House of Delegates is on file at the Medical Society office and is available to members.

REPORTS OF SPECIAL AND AD HOC COMMITTEES

COMMITTEE ON AGING AND MEDICAL DISABILITIES

The Committee on Aging and Medical Disabilities met quarterly in the past year. Dr. Wayne Zwick left the state, and Dr. Roger B. Rodrigue took over as chairman. The chair acknowledges the work of Dr. Zwick in leading the committee. The committee continues to meet as a group with a special interest in Geriatrics and the care of the elderly, with representatives from the Medical Society of Delaware, the State of Delaware, and the Delaware Health Care Facilities Association.

Ms. Eleanor Cain, Director of the State of Delaware Division of Services for the Aging and Adults with Physical Disabilities (DSAAPD), kept the committee informed of changes which affected the care delivery system for the elderly in the State of Delaware. This information included the departmental reorganization plans and legislative changes which impacted on the health care delivery system.

The Annual Geriatric Symposium focused on the delivery of care in planned integrated models and was well received, with an audience of over 200 physicians, nurses and the public. The speakers included representatives of the DSAAPD, who discussed options for care of the elderly and physically disabled with and without Medicaid in Long Term Care.

The committee also studied and discussed Secretary Nazario's letter regarding Options for Medicaid Managed Long-Term Care and information from the MEDSTAT Group Inc. regarding selected options for a feasibility study in Delaware.

There were discussions on the scope and membership of the committee as well as the need for wider representation of the specialties including psychiatry, psychology, orthopedics, physiatry, ophthalmology and the nursing homes care providers. This was accomplished with appointments to the committee.

The committee received reports from the Older Women's Health Campaign by Dr. Deborah Ehrenthal on medical issues of special interest to that group.

The activities of the Nursing Homes Regulations Committee, which included representatives from this committee, was followed. With legislation already passed and regulations issued, it is now apparent that this committee's representation is no longer necessary.

The State Legislature held hearings on nursing home care chaired by Senator Robert Marshall. The panel's report was provided to the committee and reported on by Dr. Robert Frelick. The committee's comment was that many regulatory decisions are difficult to support medically and that medical expertise is lacking in the decision-making process.

Ms. Cain reported to the committee on the new Division of Consumer Protection. This division includes the Long Term Care Ombudsman Program, Licensing and Certification, and the Long Term Care Section of Medicaid. The reorganization retained Adult Protective Services in her division. She reported the regulations for Assisted Living Facilities are now in effect.

A conference on Managed Long-Term Care was attended by one committee member. Models for the integration of physician services into a system with care managers coordinating and arranging patient care in various settings were presented by several representatives of states from around the nation.

The Beach Day Senior Wellness Fair for senior citizens from throughout Delaware was held on Friday, September 18, in Rehoboth Beach, and was again well attended by the public. The physicians planning and attending this function are looking at ways of

making this more attractive to the public with more screening and educational programs.

Roger B. Rodrigue, M.D., M.P.H.
Chair

The report was filed.

CHARITABLE SERVICES

The Charitable Services Committee met several times during the year. Our main focus of activity continues to be the Claymont Health Service, which recently moved into a new facility which includes a large waiting area. This has been a great improvement in our facilities and has met with great enthusiasm by physicians and patients alike. We have also investigated a joint effort with physicians in Sussex County, particularly among the Hispanic community. We are always in the market for volunteer physicians, especially in Ob-Gyn, to see patients at the Claymont facility on a part-time basis and there also continues to be a need for referral physicians in the area of ophthalmology, ENT, orthopedics, and dermatology.

Dennis R. Witmer, M.D., F.A.C.S.
Chair

The report was filed with a commendation to Dr. Witmer and volunteer physicians at the Claymont Health Services.

ENVIRONMENTAL AND PUBLIC HEALTH COMMITTEE

The Environmental and Public Health Committee will have met six times by the end of 1998.

We continue to have a small interested group and are always look-

ing for others to join us. This year we reviewed several pieces of legislation related to our interest in EPH. We supported SB 173 relating to fluoridation of water supplies. We did not support the idea of trading pollution 'credits' (HB 399) or the construction of any more waste incinerators in the state. We reviewed the indoor air quality report by the task force from house concurrent resolution 72 last year. While it was noted no physician was on the task force, the committee did agree with the bulk of the report. There were 17 recommendations in six different areas including better information and education on IAQ as well as better maintenance and housekeeping quality in public schools and state-owned buildings.

Dr. Robert Jackson of the Division of Public Health reported to us about proposed changes in the regulations for the control of communicable and other disease conditions. These include dropping amebiasis as a reportable disease and adding various antibiotic resistant microorganisms. Also, HIV would change from a class B to a class A reportable disease, which would make it reportable by name. He had very compelling reasons for this and noted that currently 33 states require HIV reporting by name. The CDC also recommends this practice. There would be an elaborate process to protect confidentiality. The EPH committee recommended that the MSD support the proposed changes.

Our PPIP project is slowly moving forward. Thanks to committee members' persistence, we hope to have preventive care flow sheets mailed out to primary care physicians before the end of the year. We will be looking for feedback on how useful these sheets are.

Doctors Joel Chodos and James M. Gill will be doing a workshop at the annual meeting titled "Cancer Screening: What Should We Be Doing?"

We continue to try to connect with the various people and organizations around the state that are involved with the public's health. We are always looking for ways to increase the interchange between those people/groups and the practicing medical community. Please join us.

John J. Goodill, M.D.
Chair

The report was filed.

MATERNAL AND CHILD CARE COMMITTEE

The Maternal and Child Care Committee has to continue to work on several issues important to maternal-child health in Delaware. At issue during the past year has been the lack of insurance coverage for non-US citizens, HIV-prenatal testing, and interactions with the Delaware Perinatal Board.

The committee has continued to note with concern the effect of national legislation that, in effect, bars state Medicaid programs from using Federal dollars to fund medical services for non-US citizens. A result of this policy is the lack of adequate — and in many cases, any — prenatal care among the members of this population with the resultant fear that the infant morbidity and mortality rates will increase among a population of children who are, in fact, US citizens. Support was voiced for the continuing efforts under the leadership of the March of Dimes' Public Advocacy Committee to obtain such coverage. During the

1997 legislative session, the State Legislature refused to provide this funding through the Delaware Health and Social Services Medicaid program.

In the last session of the State Legislature, Representative Pamela Maier introduced legislation that would provide mandatory HIV-testing for all pregnant women. Several years ago, this committee introduced this concept at a Medical Society House of Delegates meeting in the form of a resolution. The knowledge with regard to the treatment of this disease has evolved to the point that most members of the committee commended Representative Maier's efforts. The committee did have some concerns with regard to the penalties for violation of this law, which is defined as an unclassified misdemeanor. The committee recommended that the Society support Representative Maier's proposal to require HIV-prenatal testing and also supported a change in the law that would require positive HIV-results be reportable by name.

Through the Standards of Care Committee of the Delaware Perinatal Board, guidelines are being developed to assist in the management of prenatal drug exposure, gestational diabetes, and Group B betahemolytic Streptococcal infection. In a report to the Maternal and Child Care Committee, the Standards of Care Committee noted that more pediatric input would be appreciated in the development of these guidelines. Interested parties are invited to attend the meetings of this committee, which are generally held on the fourth Thursday of each month at 6:30 p.m. at the Rehabilitation Center at Bayhealth Medical Center: Kent General Hospital in Dover. (Directions can be obtained by calling 302-733-2673.

Nancy Oyerly, R.N., the chair of the Scientific Committee of the Perinatal Board, presented the "Strategic Framework for Infant Mortality Reduction in Delaware." During 1998 to 1999, the Perinatal Board will concentrate on the problem of Sudden Infant Death Syndrome and the higher mortality rate associated with infants sleeping in prone position and other risk factors.

The Maternal and Child Care Committee will continue to work to improve the health of mothers and their children through initiatives with the Delaware Perinatal Board and other concerned parties in the State of Delaware.

Garret H.C. Colmorgen, M.D.
Chair

The report was filed.

MEDICINE AND RELIGION COMMITTEE

The committee met on October 6, 1998, to make plans for the 1998 Annual Prayer Breakfast on November 21. For the past few years, our sole function has been to plan and host the Prayer Breakfast at the Annual Meeting of the Medical Society of Delaware.

The committee reviewed the programs for the annual prayer breakfast over the past 12 years. The committee noted the diversity of the programs in the past with regard to music, readings and oral presentations.

The committee concurred with a proposal that Mr. Wilson Somers, Choral Director at the Tatnall School and Music Director and Organist at St. David's Episcopal Church, be invited to present a musical presentation. Mr. Somers has agreed, and the title of his presentation will be "Music as

Ministry." The Invocation and Benediction will be given by Dr. Eric Ruoss, Tatnall School Headmaster.

There was discussion regarding the annual physician/clergy breakfast, which was formerly held in the spring of the year. The committee expressed its regret that this program is no longer sponsored by the Society.

Janice E. Tildon-Burton, M.D.
Chair

The report was filed.

MEDICO-LEGAL AFFAIRS COMMITTEE & JOINT COMMITTEE OF PHYSICIANS & ATTORNEYS

Since the final draft of the Interprofessional Code was approved by this committee and subsequently by the Board of the Medical Society and the Board of the Bar Association, these committees have not had any formal meetings.

A number of young physicians indicated in the survey earlier this year they wished to be involved in the affairs of the committee and their names have been added to the list of committee members.

A few questions have arisen regarding fees for deposition, reports, etc., and these have been dealt with without the need for a committee meeting.

John T. Hogan, M.D., F.A.C.S.
Chair

The report was filed.

MENTAL HEALTH, ALCOHOLISM AND DRUG ABUSE COMMITTEE

There is no report from the Mental Health, Alcoholism, and Drug Abuse Committee. The commit-

tee did not meet during the past year.

Neil S. Kaye, M.D.
Chair

The report was filed. The Reference Committee noted that there has been very little activity by this committee, since many of its functions have been handled by Public Laws and some other committees but that this committee has in its charge some very serious public health issues: mental health, alcoholism and drug abuse. The Reference Committee felt that new functions for this committee should be considered, such as developing education for physicians on drug and alcohol abuse and also education of the public. It also thought that we should consider forming a liaison with the court system for evaluating rehabilitation of drug offenders.

PHARMACY COMMITTEE

The Pharmacy Committee addressed the following issues during the past year:

1. Senate Bill 339 - Legislation to Expand the Pharmacists' Scope of Practice

The original version of this bill was intended to expand the pharmacists' scope of practice to include the administration of injectable medications, biologicals and immunizations. It also intended to allow pharmacists to perform capillary blood tests to be used in adjusting the patient's medical therapy. The Pharmacy Committee expressed the Medical Society's opinion that the bill was too broad and it did not provide adequate patient safeguards. Committee recommendations were not accepted by the Board of Pharmacy and so the Pharmacy Committee chair personally appeared before the Senate

Committee to present our views. This resulted in extensive revision of the proposal. The final bill limited the pharmacists' authority to administration of adult immunizations only and then only pursuant to a valid prescription from a physician treating his own patient population. The Board of Medical Practice shall be involved in establishing requirements that the pharmacists must meet in order to be able to administer injectable immunizations. In addition, the pharmacist's authority to perform capillary blood tests was limited to performing these techniques only to facilitate patient education in the use of home glucose monitoring equipment. No blood tests to adjust medical therapy were provided.

2. Collaborative Drug Therapy Management Act

This proposal from the Board of Pharmacy is intended to allow Pharmacists to work with individual physicians in setting up protocols by which medical therapy can be adjusted. This proposal is currently in its 13th draft. The Pharmacy Committee has proposed establishing a joint committee with representatives from the Medical Society and the Board of Pharmacy in order to work out acceptable language, which will preserve the physician's control of the therapy prescribed. Ongoing work in this regard will continue.

3. Inspections from the office of Narcotics and Dangerous Drugs (ONDD)

The Office of Narcotics and Dangerous Drugs (ONDD) has announced that it will be conducting inspections of individual physician's offices in the near future. The Pharmacy Committee discussed this with

the Director of ONDD. It was determined that these inspections would be for educational purposes only. Physicians who dispense scheduled medications from their office are required to maintain substantial records. The Pharmacy Committee will be assisting the ONDD in educating physicians as to their responsibilities. In a future Medical Society Newsletter, highlights of these regulations will be published.

4. Ongoing Communication

The Pharmacy Committee continues to facilitate communication of the concerns of the members of the Medical Society to the Board of Pharmacy, the Pharmaceutical Society, Controlled Substance Advisory Board and the Medicaid Drug Utilization Review Board.

Michael J. Pasquale, M.D., F.A.C.C.
Chair

The report was filed with a commendation to Dr. Pasquale for his excellent work, both as a physician and pharmacist, in chairing this committee. The Reference Committee also felt that the Pharmacy Committee should consider evaluating alternative medical therapies as part of its work.

PHYSICIANS' HEALTH COMMITTEE

The Committee has had a number of new cases. The scope of problems has been varied, with approximately fifty percent of the cases involving substance abuse and the remainder comprised of varied issues.

Existing cases have continued to be followed and monitored.

A memorandum of understanding with the Board of Medical Practice has been crafted by a sub-

committee, and a final revision is currently in preparation.

The Committee's Chair has been appointed to serve on the Professional Guidance Committee of the Delaware Bar Association, that Association's committee analogous to ours, to assist attorneys with similar difficulties.

Carol A. Tavani, M.D., F.A.P.A.
Chair

The report was filed with commendation to Dr. Tavani for her work on the committee and the excellent relationship she has developed between this committee and the Board of Medical Practice.

PRISON HEALTH COMMITTEE

The Prison Health Committee, as a whole, has met only once this year. Attempts are being made to schedule another meeting and to have the Prison Commissioner meet with us. We have also met with the Prison Health Service representatives twice for overviews of current prison health. I visited Gander Hill, the new women's prison (Delores Baylor Women's Correctional Facility) and the Delaware Correctional Facility at Smyrna to see their medical departments and learn about the programs offered.

On the positive side:

- Prison Health Services has a new Medical Director who formerly worked in California and recently headed PHS's Indiana facilities. The previous head will remain as chief medical officer for the Smyrna prison. Two new doctors will work at Gander Hill and Baylor plus a new OB-GYN.
- Decrease in number of medical grievances due to improved grievance procedure and review.

- Four negative pressure cells, one at each major facility, for isolation of infectious disease cases.
- New "secure" health unit for 12 prisoners being built at St. Francis Hospital to be opened by the end of this year.
- Psychiatric services are being provided weekly for both Gander Hill and DFC (Smyrna) by Carol A. Tavani, M.D.
- Drug and alcohol rehab training is provided.
- Four percent of prisoners are known to be HIV positive; by statistics, probably another four percent have the disease but refuse testing. Triple therapy is used.

On the negative side:

- Overcrowding is number one problem (except new female prison).
- Difficulty taking prisoner(s) to private physician's office or hospital for specialized or emergency care. Requires two guards per prisoner; costly, time consuming, awkward for doctor, prisoner, and prison.
- Drugs and alcohol are still big problems in all prison facilities.
- Need for more dental, diabetic foot care.

The Committee will continue to oversee Prison Health. Liaison with the Delaware Center for Justice has been very helpful.

William D. Shellenberger, M.D.
Chair

The report was filed.

SCHOOL HEALTH COMMITTEE

The School Health Committee met twice in 1998, and the chairman attended a statewide meeting sponsored by The Governor's Council on Lifestyle and Fitness. The subject of all three of these meetings was the problem of the decreased level of vigorous physical activity among children in Delaware's public schools. The Medical Society's School Health Committee has been charged by the Board of Trustees with the task of developing a seminar that will bring together school administrators, physicians, and physical education experts to discuss ways that the situation might be improved.

Our efforts to that end have been temporarily put on hold pending the determination by Dr. Alan Waterfield, of the University of Delaware, of the role that the Medical Society might best play in a statewide effort to increase the level of physical activity of all Delawareans. Should Dr. Waterfield's inclusive efforts fail to produce much action, then the Medical Society may need to resume its independent plan. Dr. Waterfield's statewide agenda is expected out this month, November 1998, and is eagerly awaited.

Diana Dickson-Witmer, M.D.,
F.A.C.S.
Chair

The report was filed.

ADVISORY COMMITTEE TO THE BOARD OF MEDICAL PRACTICE

Members of the committee made themselves available to the Board of Medical Practice as needed during the past year.

The Advisory Committee to the Board of Medical Practice was formed over two years ago to as-

sist the Board of Medical Practice in adjudication of allegations concerning physicians about whom a preliminary investigation by the Board has determined that reason exists for the Board to take definitive actions. The advisors are not paid for their efforts. The voluntary cooperation of the physicians has been gratifying.

Martin Gibbs, M.D.
Chair

The report was filed.

AD HOC CHILD ABUSE TASK FORCE

This group was formed last year in response to an increased level of public concern regarding the problem of child abuse in Delaware. Our most important contributions at that time included discussions with Secretary Eichler, the clear establishment of the Medical Society of Delaware as a critically interested party, and the organization of a symposium on child abuse, which was well attended and generally successful. This year the group has been less active but is still working on another symposium, which will be held this year on Tuesday, December 1, at the MBNA Conference Center in Newark beginning at 8:00 a.m.

Charles L. Reese IV, M.D.
Chair

The report was filed.

DELAWARE CARRIER ADVISORY COMMITTEE (DELCAC)

For those who are not yet aware, HCFA mandated a few years ago that each local Medicare carrier establish a carrier advisory committee, consisting of local physicians of every specialty, as well

as State Medical Society representatives, "to provide a formal mechanism for physicians in the State to be informed of and participate in the development of local medical review policy (LMRP) in an advisory capacity." Other stated purposes include: "To provide a mechanism to identify areas which need improvement in the administration of the Medicare program and achieve resolution of problems identified, and to provide a forum for information exchange between physicians and Medicare."

Delaware's CAC has been in existence now for a few years. At the beginning of this year, as most of you know, Delaware's Medicare carrier changed from XACT (Blue Shield of Pennsylvania) to TrailBlazer Health Enterprises (Texas Blue Shield). The frequency of meetings is now every four months, with the next meeting scheduled for early February of 1999. Each CAC has two co-chairs, one being the Medical Director of the Medicare carrier, in our case, Dr. Michael Riisager of TrailBlazer, and the other a physician from among the local CAC membership. Dr. William Nottingham served admirably as the local physician co-chair of DELCAC from its inception, and resigned from that position in early 1998. I have recently been asked to serve as the new co-chair for DELCAC.

The agenda for each meeting is put together by the carrier Medical Director, Dr. Riisager, but may include any items referred by physician members to myself or to Dr. Riisager. Such items may include any issues of concern about Medicare local medical policies, administrative issues, and national or other issues which physicians believe need clarification or communication to HCFA. One of the most important primary functions

of DELCAC is to participate in medical review policy development. Whenever TrailBlazer puts together a new or revised local medical review policy (LMRP) on any coverage or reimbursement issue, a draft of such proposed policy is submitted to the members of DELCAC prior to the next scheduled meeting. There then follows a required 45-day "notice and comment" process, during which any members of the CAC, or other physicians within the community through their CAC representatives, may submit comments regarding the draft LMRP. The notice and comment period starts on the day of the meeting. Any written comments submitted to the carrier Medical Director are then considered before the final medical review policy is implemented. Beyond that implementation date, it is still possible to effect changes in LMRPs, especially of a minor nature.

Each of the CAC members is expected to disseminate pertinent draft policies to their colleagues in their respective specialty societies, and to solicit additional review and comment necessary to ensure that the policy that is finally put in place reflects the standard of practice in our state. Each is also expected to disseminate information about Medicare issues obtained at the meeting, as appropriate to their specialty, to their colleagues, and to bring information to Medicare through the CAC about pertinent issues, including administrative problems, inconsistent or conflicting medical review policies, new technology and non-labeled drug use, etc., so that they can be addressed in a timely fashion. In order for your designated representatives to do their jobs, and in order for the CAC to serve a truly useful purpose, communication between rank and file physicians and their respective CAC representative(s) is necessary. Please make it a point to know who your CAC representative is, and to communicate any

issues to his or her attention that are within DELCAC jurisdiction and warrant our attention.

Peter Panzer, M.D.
Co-Chair

The report was filed. The Reference Committee would like to bring to the membership's attention the need and importance of ongoing individual and specialty group input to the review of proposed changes in Medicare policy and also encourage the Medical Society of Delaware Board of Trustees to develop an agenda to enhance membership awareness to the value of this committee.

REPORT OF THE STRATEGIC PLANNING OVERSIGHT COMMITTEE

The Oversight Committee (OC) is a new ad-hoc committee created at the conclusion of the Strategic Planning Retreat in March 1998. The OC is charged with assuring that the plans and goals made at the retreat are carried out. The committee has met three times. A summary of the proceedings of the retreat is included in the Report of the President-Elect.

Some of the work needed to accomplish the goals of the strategic plan was assigned to existing committees. New committees that have been or will be created will do the rest. At this time, all of the goals of the retreat have been acted upon. Some of them have been fully achieved. The following is a summary of the accomplishments to date:

Goal #1:

To assist physicians in Delaware communities in forming autonomous local multi-specialty networks as the vehicle to restore physician leadership through the mechanism of risk contracting and clinical integration. This goal was assigned to MedNet. Physician

Organizations have been created throughout most of Delaware. The only area where MedNet is not represented is the BayHealth (Dover-Milford) sector. In that sector, there is a PHO that counts essentially all of the physicians credentialed by the Milford Memorial and Kent General divisions as members. Besides expanding the number of POs, MedNet has been negotiating with insurance carriers and employers since the Planning Retreat. Details are included in the MedNet report.

Goal #2:

Develop a directory of media contacts. This effort is being acted upon. Contacts with print media are being expanded and new contacts with broadcast media are being made. From these actions, the OC has concluded that the MSD will need a comprehensive media relations program in order to be effective in communicating our members' message to the public. This will require completing initial contacts with print and broadcast media followed by sustained interaction and relationship building. At least a part time MSD staff member will have to be assigned to this task. One of the goals next year will be to find and fund such a person.

Goal #3:

Initiate a Weekly Fax Bulletin of MSD News and Activities. This goal has already been accomplished. With the help of funds from an AMA grant, MSD has purchased a new fax machine that allows rapid broadcast fax transmissions to the whole membership. Each week MSD is faxing a report of the activity of the Society to all members. Periodically, urgent broadcast faxes will be transmitted to communicate urgent information about changes or

proposed changes in insurance policies, government regulations, new legislation, etc. The members of MSD are encouraged to give prompt attention to these reports and alerts so that they can act expeditiously in their patient's and their own behalf.

Let me emphasize one very important point. Our new focus on communications is not meant to be a one-way street. Your officers of the MSD are eager to receive observations and suggestions from members. We are a Society that is blessed with a bright, well educated, and insightful membership and wish to get feedback from as many as possible.

Goal #4:

Political Action: Increase membership in DELPAC by 200 members. This goal has not been realized. Please refer to the report on DELPAC for a summary of its plans to increase membership. If you are reading this and are not a member of DELPAC, we plead with you to join.

Goal #5:

Political Action: To set up a network that communicates to all Delaware physicians by fax, e-mail, hospital mail systems to send alerts and synopses of health related bills and feedback. This goal has been met by the acquisition of the broadcast fax machine described under Goal #3. Communication with the members via e-mail and hospital mail systems has not been explored as yet. We may have to use more than one type of communication with the membership depending on the preferences of each individual physician. This is being researched.

Goal #6:

Modernization: To have 100 percent of MSD publications and communications on electronic data transmission. The OC has met with a consultant who is skilled and experienced with Internet and other electronic communications systems. The consultant assisted with the creation of MSD's attractive web page, which now receives over 4,000 hits per month. The OC is developing a communications committee that will work to accomplish goals #5 and #6. The initial investigation of ways to use electronic transmission has revealed a myriad of exciting uses for this technology that would benefit our membership and our communities. Dr. Michael Katz will chair the new Communications Committee.

Goal #7:

Modernization: Establish a committee to assess physical plant options. This goal has been achieved. Working with the Delaware Academy of Medicine, the MSD has developed a plan to renovate a portion of the Academy's building that will give MSD much needed space. This will be used over the next five years, during which future needs will be evaluated.

Goal #8:

"Hassles in Practice": To develop and expand consultative contract services to include timely consultation with individual physician practices. The MSD already has done admirable work in this area. To further these aims, we created an advisory committee for the Physicians' Advocate Program. This committee is meeting and working well to prepare strategies for the membership to deal with office management and managed care issues.

Goal #9:

"Hassles in Practice": Secure one piece of legislation reducing the hassles of practice. This goal has been achieved. Prompt payment regulations have been issued from the office of the Insurance Commissioner. Also, the "due process bill" has been passed requiring insurance companies to give justification for and right of appeal to a physician they wish to exclude from their panels. These two successes of MSD are especially good examples of the product of the strategic planning process. The planning identified and focused effort on areas of particular concern to the membership and achieved solutions. Flowing from these successes, we have new goals for legislative action, which are described in the DELPAC report.

Goal #10:

Secure capital and increase revenue for operations. MSD member dues have not been raised in four years and remain the fourth lowest in the country. This is because MSD has received revenues from MSDIS (Medical Society of Delaware Insurance Services) which reduce the dues for each member by \$225 per year. MSDIS revenues and their benefit to the Society can be increased if more members and others will use MSDIS for their malpractice, home, car, life and other insurance needs. However, MSDIS funding is now limited, costs of the Society have increased and the new subsidiaries of the Society have consumed a large portion of its reserve funds. Therefore, OC has had to look at other sources of revenue. An increase in dues will have to be considered. This and other strategies have been discussed in the Budget Com-

mittee and will be presented at the annual meeting.

There is one potential other source of immediate revenue: Many more physicians have started practice in Delaware, and it is in their and the current Society members' interest that they join MSD to maintain the strength that we have in our state. The OC plans to create a membership committee to contact those new physicians and encourage them to become members.

Goal #11:

Revenue: To develop and implement guidelines and a strategy for revenue enhancement. The OC has worked toward this goal, especially evaluating physical plant needs, and is developing new budgetary mechanisms for development of new programs. Dr. Garth Koniver is to be complimented for his excellent work in this area.

The whole membership of MSD can be both satisfied with and proud of the work of the members who developed the strategic plan and the plan itself. We are well on our way to the achievement of its goals. We will also be identifying new goals, assessing their importance to the Society and working toward their achievement where appropriate.

I wish to thank all the members of the Oversight Committee and the other committees who have worked so hard for our society in these efforts. I also wish to thank Mr. Mark Meister, Mrs. Mary LaJudice, and Mrs. Beverly Dieffenbach for all their essential contributions to this committee's function and accomplishments.

Martin G. Begley, M.D.
Chair

The report was filed.

AD HOC COMMITTEE ON NEEDLE EXCHANGE PROGRAMS

The Medical Society of Delaware was asked by State Senator Margaret Henry to express an opinion on legislation that would have created a pilot needle exchange program for the Wilmington community. Since the Society had not previously addressed this issue, the President of the Society, Dr. Stephen Grubbs, appointed an ad hoc committee to address this issue. Following this summary is a copy of the "White Paper" report that that committee developed to assist Senator Henry and the rest of the State Legislature in addressing this issue. Although Senator Henry's legislation was not enacted, the Medical Society's ability to promptly provide such information for our Legislature was greatly appreciated. Attached is a copy of that report.

Stephen R. Permut, M.D., J.D.
Chair

The report and White Paper were filed. The Reference Committee commended Dr. Permut for his excellent report. The legislation which the Medical Society co-sponsored will, hopefully, be re-introduced by Senator Henry in the next legislative session.

**NEEDLE EXCHANGE PROGRAMS:
A NEED IN DELAWARE**

INTRODUCTION

The irresponsible use of needles and syringes by drug abusers has caused a large wave of community outreach programs and legislation across the world. Perhaps the most well-known effort is the implementation of Needle Exchange Programs (NEPs) to prevent the spread of diseases and death. Studies have shown that when hypodermic needles and syringes are not readily available, in-

travenous drug users tend to reuse injection equipment numerous times, and often share it with others. Consequently, blood-borne diseases may spread rapidly in populations of drug users (Report 8 of the American Medical Association Council on Scientific Affairs, (A-97). "The Reduction of Medical and Public Health Consequences of Drug Abuse. Reference Committee D, pp. 7-8).

Since the 1980s, needle-sharing has been responsible for spreading the HIV infection from one drug user to another. NEPs have been the most effective in reducing needle-sharing to prevent disease and to control drug abuse world wide (National Institutes of Health. NIH Consensus Statement. Vol. 15. No. 2. February 11-13, 1997, and Report 8 of the American Medical Association Council on Scientific Affairs (A-97). "The Reduction of Medical and Public Health Consequences of Drug Abuse. Reference Committee D, p. 8). The programs differ in format and size; however, they all share a commitment to maximizing the availability of sterile needles and syringes at multiple locations such as storefronts, outreach workers, or mobile vans. Recently, many cities have implemented "vending machines" to exchange clean syringes for used ones around the clock in high drug-use areas (Report 8 of the American Medical Association Council on Scientific Affairs (A-97), p. 8).

Currently, there are 112 needle exchange programs operating in 29 states and the District of Columbia; this is up from 21 states in 1994.

The number of cities with syringe exchanges increased from 46 to at least 71 (some do not report their locations) over the same period (American Medical News, "State Finds Needle Exchanges Effective in HIV Prevention." Stapleton, Stephanie. p.7. September 1997). Two examples are:

Connecticut: Connecticut resembles Delaware in its high AIDS statistics. In 1990, they started a demonstration project in New Haven. Later, additional sites were added because their experience was so positive. In addition to the widely available Needle Exchange Programs, Connecticut offers community outreach programs and legislation on the purchase of small numbers of needles and syringes in commercial pharmacies. These programs have reduced the rate of new infections by 39% in this population with no identifiable increase in drug use (Delaware Health and Social Services. Division of Public Health. Summary and Fact Sheet, pp. 3-5. 1997).

Massachusetts: The Massachusetts Needle Exchange Program was started in 1993 by state law for Boston and Cambridge. The program was successful in enrolling 1,315 clients, exchanging 37,575 syringes, and linked 16.6 % of eligible clients to drug treatment programs. An evaluation by The Medical Foundation (Final Report: The First Year of the Pilot Needle Exchange Program in Massachusetts, October 1995) found there was no increased crime, no initiation of young people into drug use and injection, no attraction of addicts from areas beyond Boston, and no increased needle stick injuries to public workers.

The state of Delaware needs to give Needle Exchange Programs serious consideration due to its staggering statistics regarding HIV infection from intravenous drug users. Delaware's HIV infection rate from IDUs is more than twice the national average, and the state's overall rate of new AIDS cases is among the top six or seven states this year. In 1995, 65% of Delaware's new cases of HIV were traced directly or indirectly to IDUs. In 1997, the figure has jumped to 75% of new HIV cases (Delaware Health and Social Services. Division of Public Health. Summary and Fact Sheet, pp. 3-5. 1997.)

Needle Exchange Programs are known to reduce the number of infected syringes and needles being used in the IDU population by up to 75% and the new infection rate in participating users from 6-7% to less than 2%. Also, Needle Exchange creates opportunities to provide education and other preventive services to a population that is hard to reach (Delaware Health and Social Services. Division of Public Health. Summary and Fact Sheet, pp. 3-5. 1997).

LEGISLATION

Some legislators are concerned that Needle Sharing Programs will in effect condone drug use and criminal behavior. A series of federal government studies have demonstrated that the rate of new HIV cases caused by injection drug use can be cut by 30% using needle exchange programs.

Considering the federal government's stance on the issue and Delaware's urgent need to implement these programs, in December 1997

Delaware State Senator Margaret Rose Henry introduced Senate Bill 225, an Act Amending Title 29, Delaware Code establishing an AIDS Prevention Sterile Needle and Syringe Exchange Pilot Program to operate within the City of Wilmington.

The bill includes the State Senator's reasons for establishing the program based on studies and facts about Needle Exchange Programs as follows:

- The programs provide HIV testing, health counseling information on the dangers of contracting AIDS by engaging in high risk behaviors, and protecting oneself from infection.
- The programs do not increase the number of needles on the streets and can potentially reduce the number of discarded needles.
- The programs are a resource in curbing drug abuse by providing information and referrals on substance abuse counseling.
- The programs are endorsed by numerous medical organizations including the American Medical Association and The American Academy of Pediatrics.

PROGRAM COSTS

The lifetime cost of a single case of AIDS is estimated to exceed \$119,000, which exceeds the costs of many existing needle exchange programs. AIDS is not the only disease prevented by an effective needle exchange program: Hepatitis C, Hepatitis B, and a variety of other diseases and

conditions would be impacted as well (Delaware Health and Social Services. Division of Public Health. Summary and Fact Sheet, p. 5. 1997). Operating budgets for needle exchange programs run around \$169,000, with a range of \$31,000 to \$393,000, or 71 cents to \$1.63 per syringe distributed. Mathematical predictions reveal that the programs could prevent HIV infections among clients, their sex partners, and offspring at a cost of \$9,400 per infection averted. This is far less than the lifetime cost (\$119,000) of treating an HIV infection (National Conference of State Legislatures, "HIV/AIDS Facts to Consider", p. 45).

The Needle Exchange Program in Wilmington, Delaware, will use a mobile van to offer HIV testing, health counseling information on substance abuse treatment, and a one-to-one needle exchange program. The estimated cost of this program is \$378,500 for 200 clients (Ad Hoc Committee Minutes, January 28, 1998).

MSD AD HOC COMMITTEE ON PROPOSED NEEDLE EXCHANGE PROGRAM

At the direction of the Board of Trustees of the Medical Society of Delaware, an Ad Hoc Committee on the proposed Needle Exchange Program was formed to review the AMA's position statement on needle exchange programs and report back to the Board in the first quarter of 1998. The Ad Hoc Committee, chaired by Stephen R. Permut, M.D., met at 8:00 a.m. on Wednesday, January 28, 1998, at the Delaware Academy of Medicine.

The committee agreed that in light of the nature and cost of

the disease (HIV), any program that reduces the incidence of HIV should be supported. The Ad Hoc Committee on Needle Exchange Programs therefore recommended to the Board of Trustees that the Medical Society of Delaware support the proposed needle exchange program for the following reasons:

- Needle exchange programs help prevent the spread of HIV/AIDS among drug users and innocent bystanders.
- Needle exchange programs can provide a venue for interacting with the drug-using population to provide medical services and access to rehabilitation and support services.
- An extensive review of the literature demonstrates that needle exchange programs do not increase the use of drugs.
- Needle exchange programs will help prevent the spread of HIV/AIDS among unknowing sexual contacts and newborns.

The Ad Hoc Committee's recommendation was adopted by the Medical Society of Delaware's Board of Trustees when it met on April 9, 1998.

CONCLUSION

Overall, the studies and figures show that Needle Exchange Programs have brought a sense of hope and control to fighting the war on drugs and preventing the spread of HIV. There are no proven negative effects to implementing these programs, but there are many positive ones. The cost estimates show that the total costs of running a needle exchange

program is minimal compared to the expense of caring for infected HIV and AIDS patients. For this reason the Medical Society of Delaware supports passage of Senate Bill 225 as a part of a comprehensive program to halt the spread of HIV/AIDS and to make Wilmington as well as the larger community a safer place for Delawareans.

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ACKNOWLEDGEMENT

This report on "Needle Exchange Programs: A Need in Delaware" was prepared with the assistance of Niki Papachrysanthou, a student in the University of Delaware's technical writing program. Ms. Papachrysanthou served as an intern at the Medical Society of Delaware during the spring 1998 semester. The Society appreciates Ms. Papachrysanthou's help with this project.

AD HOC COMMITTEE ON AMA UNIFICATION

At the House of Delegates meeting in 1992, a policy was adopted requiring a vote on unification by the House every three years. With 1998 the year for consideration of this issue again, Dr. Stephen Grubbs appointed an ad hoc committee to address the pros and cons of a unified AMA membership policy.

The committee, which included physicians who were pro-AMA unification as well as those who opposed it, met on September 15, 1998. The minutes from the meeting were forwarded to the Society's Board of Trustees for its meeting on October 8, 1998, at which time the Board of Trustees endorsed the existing AMA unification policy and strongly encouraged the House of Delegates to

vote in favor of continued AMA unification (Resolution 98-1).

Stephen R. Permut, M.D.
Chair

The report was adopted. The Reference Committee commended Dr. Permut and the Ad Hoc Committee for their excellent work on the very difficult, important issue of AMA Unification and recommended that Resolution 98-1 be approved. Resolution 98-1 was adopted by the House of Delegates.

REPORT OF COUNCIL OF SPECIALTY SOCIETIES

COUNCIL OF SPECIALTY SOCIETIES

Representatives of the specialty societies were invited by President Stephen S. Grubbs, M.D., to submit reports for inclusion in the House of Delegates handbook. The reports that were submitted follow.

ASTHMA, ALLERGY, AND IMMUNOLOGY SOCIETY OF DELAWARE

In the last year, the Asthma, Allergy, and Immunology Society of Delaware supported the IMPACT Tobacco prevention measures, HB 194, HB 248, and SB 223. New officers were elected in February 1998. Dr. Charles Lee was elected as President, and Dr. Gregory Marcotte was elected as Vice President. The Semi-Annual Meeting of the Asthma, Allergy, and Immunology Society of Delaware was held in Wilmington on July 24, 1998. Dr. Peter S. Creticos, of the Johns Hopkins Asthma and Allergy Center, reviewed current

issues and controversies with the use of inhaled corticosteroids.

The Asthma, Allergy, and Immunology Society of Delaware was represented at the annual American Academy of Allergy, Asthma, and Immunology (AAAAI) meeting held in Washington, DC, in March 1998. Issues discussed at the Regional, State, and Local Allergy, Asthma, and Immunology Societies forum at this meeting included the development of new practice parameters, concerns about E&M documentation guidelines, and recent supply problems with certain immunotherapy extracts and IVIG.

Pollen counts have been provided for Delaware allergists during the 1997 and 1998 pollen seasons. A summary of regional pollen counts was also submitted to the National Allergy Bureau and the AAAAI.

The American College of Allergy, Asthma, and Immunology (ACAAI) annual meeting will be held in Philadelphia, PA, in November 1998. Dr. Andrew Weinstein will be representing the Asthma, Allergy, and Immunology Society of Delaware.

Concerns about coding interpretation continue. HCFA has recently changed the interpretation for the code for allergy immunotherapy extract. As a result, Medicare patients can only be billed for one vial of extract, even though more than one vial may be medically indicated. Dr. William Geimeier has been in touch with the Joint Council of Allergy, Asthma, and Immunology (JCAAI), which has requested that this rule be reversed. The JCAAI will be meeting with HCFA in October 1998 to discuss this issue.

Upcoming events for the Asthma, Allergy, and Immunology Society

of Delaware include a 1999 meeting and the 1999 AAAAI and ACAAI meetings.

Charles E. Lee, M.D.
President

The report was filed.

DELAWARE ACADEMY OF FAMILY PHYSICIANS

The Delaware Chapter of the American Academy of Family Physicians has had an active year. Our Past President, Soma Padmalingam, M.D., chaired a very successful annual meeting in May, at which time I was installed as the president of the Delaware Chapter.

We have been very active providing continuing medical education opportunities to our membership. We have a Fall as well as a Winter CME course. Each course runs over 10 consecutive weeks, and enables the members to earn 30 hours of CME credit. These courses are well supported with excellent lectures being given by many members of the Medical Society of Delaware.

We also have quarterly business meetings at which an hour-long educational lecture is given. The location of these meetings alternates between all three counties of the state, enabling us to maintain close contact with all our members.

The Annual Geriatric Medicine Symposium is continuing to grow in popularity. Dr. Roger Rodrigue is finalizing the agenda for this year's meeting, which will be held December 8, 1998. Dr. William Funk chairs the Continuing Medical Education Committee for the State of Delaware, and was responsible for approving over 300 CME hours last year.

On a national level, we have excellent representation at the American Academy of Family Physicians, and are very appreciative of the efforts of our delegates who attended the Annual Meeting of the AFAR. Dr. M. Diana Metzger chairs the Delaware Academy of Family Physicians/Research and Education Foundation. The Foundation has been active in providing educational opportunities for medical students to spend part of their summer vacation with practicing family physicians.

I thank you for allowing us to submit a report for your members.

Paul A. Kaplan, M.D.
President

The report was filed.

DELAWARE ACADEMY OF OPHTHALMOLOGY

The Delaware Academy of Ophthalmology has been concerned about the many changes facing medicine in general and ophthalmology in particular. The year Oklahoma optometrists gained the legal right to perform laser procedures for patients – a further expansion of their scope of practice. While they are the first state to do so, there are concerns that like the domino effect, more states will follow. Optometrists have been especially active in recent weeks in attempting to obtain hospital privileges. The DAO is a member of the Metro-East group of states in the American Academy of Ophthalmology including New Jersey, New York, and Pennsylvania. There is concern that a laser bill will be introduced in one of our states. At the mid-year Forum of the American Academy of Ophthalmology held in Washington, DC, in the spring, the other states in our region expressed

concern that Delaware, a small state, may see a laser bill. Current law prohibits optometrists from performing laser surgery in our state, but the DAO remains watchful through our lobbyist, Mr. Phil Corrozi. Our Executive Committee remains concerned about these issues and hopes to continue to work with the Medical Society of Delaware in this regard.

We've recently hired Mary LaJude of the Medical Society of Delaware staff as our part-time executive director. This will help us accomplish many of the goals the Executive Committee has identified to aid our membership and improve our public service programs.

We continue to work with one of the local Lions Clubs in providing an annual eye-screening event. We'd also like to develop, with the Medical Society, more programs to serve our members.

Dorothy M. Moore, M.D.
President

The report was filed.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, DELAWARE SECTION

This year's 46th Annual Clinical Meeting (ACM) of the American College of Obstetricians and Gynecologists (ACOG) was held in New Orleans, LA. There were more than 4,700 physicians enrolled and a total attendance of 12,000. Highlights of this year's ACM included the following:

Installation of James P. Youngblood, M.D., as the 47th President of ACOG.

Discussion regarding insurance coverage of prescription contra-

ceptive medication, specifically, the planned coverage of Viagra for men and the failure of insurance plans to cover the birth control pill (BCP). The discussion raised the issue of "gender bias" and a double standard with regard to women and prescription medications.

Announcement of an aggressive national program to help prevent osteoporosis, an urgent women's health issue that has reached epidemic proportions. ACOG will team up with the creators of the "milk mustache" campaign to develop nutrition educational materials for physician offices. To help educate women on the importance of drinking milk and calcium intake, ACOG has joined the Milk Processor Education Program and National Dairy Council in developing educational materials for office waiting rooms.

Announcement of new medical guidelines for pregnant women who have had a C-section. ACOG will recommend that physicians be more cautious in advising women to attempt vaginal birth after C-section (VBAC). The revised guideline is due out in December 1998 and will still recommend VBAC as a good option for many women. It will also recommend that physicians make their patients aware if there are increased risks for them.

At this year's ACM, the Delaware Section received two prestigious awards. The first was the President's Community Service Award that was presented to Garrett H. C. Colmorgen, M.D. ACOG and Wyeth-Ayerst Pharmaceuticals established the President's Community Service Award to recognize one Fellow from each of the ten ACOG Districts who has performed outstanding service to the community or area served. Each District

establishes its own selection process. The individual selected must have demonstrated distinguished service to the female population in the community in the discipline of obstetrics and gynecology. Dr. Colmorgen has more than a decade of volunteer service to the women of Delaware. His activities in this regard have contributed in a significant way to the reduction in the infant mortality rate reported recently in Delaware.

The second award received by the Delaware Section was the Section Award. The Wyeth-Ayerst Section Award was established by ACOG in 1971. The award is given to the Section judged by the Council of District Chairs to have contributed most to the field of obstetrics and gynecology. The award for 1997 was presented to the Delaware Section for our activity entitled, "The Establishment of a Section Office by a Small Section." This Section office played an important role in the Section's legislative initiative that ended with passage of Senate Bill 78. The combined Section office with New Jersey has become a model for other Districts and Sections across the country.

Richard W. Henderson, M.D.
Chair

The report was filed.

DELAWARE CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

The Delaware Chapter of the American College of Emergency Physicians (ACCEPT) represents the more than 100 emergency physicians who staff our state's emergency departments 24 hours a day, seven days a week. Delaware ACEP has had a busy legislative year.

On the national front, representatives have gone to Capitol Hill to meet with our legislators' health staff to gather support for the "Prudent Layperson" language in several bills considered by Congress this year. This standard requires insurers to cover emergency services if a prudent layperson believes he or she was experiencing a medical emergency. This coverage was given to Medicare, Medicaid and Champus insured patients in the 1997 Balanced Budget Act. This standard is lacking in the current Republican legislation, the so-called Patient Protection Bill (HR 4250), but will be going to conference where we hope to have the standard included.

Representatives from national ACEP joined with other specialty groups at the AMA level in the ongoing fight opposing the burdensome changes in the HCFA guidelines.

Locally, Delaware ACEP joined the Delaware Tobacco Prevention Coalition and other specialty organizations in supporting the tobacco excise tax increase, the healthy lifestyle education first bill and the affordable health insurance legislation. We also joined the Delaware Trauma surgeons in support of the primary seatbelt legislation last year and look forward to passing this legislation in the coming year. We also supported the lowering of the BAC (blood alcohol concentration) level for DUI from 0.1 to 0.08.

Emergency physicians also teach a Sophomore Seminar in Emergency Medicine at the Jefferson Medical College each semester. This class, which routinely closes out early in the registration period, allows the medical students to hear about emergency management of several serious ill-

nesses as well as observe in the Christiana Hospital ED for four hours.

Through our quarterly meetings and a new e-mail system for our membership, Delaware ACEP members are kept abreast of changes in the state EMS system. All five of Delaware's EMS directors are ACEP members. Through this active participation, emergency physicians can impact on the care our patients receive prior to arriving in the ED.

John F. Madden, M.D., F.A.C.E.P.
President

The report was filed.

AMERICAN ACADEMY OF PEDIATRICS

The Delaware Chapter of the American Academy of Pediatrics has been actively involved in the development of the State of Delaware child health insurance programs during the past year. This program will be implemented effective January 1, 1999, and will expand insurance coverage to the uninsured pediatric population through age 18.

There was major legislative activity over the past year, and the Chapter was actively involved in the pharmacist's bill, which sought immunization and laboratory privileges. A substitute bill that does not include immunization for children was passed.

On July 1, 1998, the new officers of the Delaware Chapter of the AAP assumed their positions. These officers include myself as President, Matthew Gotthold, Vice President, Kevin Sheahan, Treasurer and Carol Owens, Secretary. The Board of Directors and new officers held a strategic planning retreat in August 1998.

In addition, our Chapter is reviewing our financial and legislative policies as well as the bylaws. We are pleased to add that we have added as Executive Director, Donna Hurley. In addition, the Chapter now has established a telephone and address to centralize communications: PO Box 605, Wilmington, DE 19809, 302-778-3908. It is our hope that this will improve the visibility of the Chapter as a resource to organizations throughout the State involved in child health issues.

The AAP celebrates Child Health Month in October. This year's theme is substance abuse prevention with a focus on alcohol prevention. The Chapter has planned statewide activities including a poster/essay contest, various defensive driving programs, and alcohol education programs in conjunction with school-based health centers.

The Chapter looks forward to a strong relationship with the Medical Society of Delaware particularly in the areas of child health related issues.

Julia M. Pillsbury, D.O.
President

The report was filed.

DELAWARE SOCIETY FOR CLINICAL ONCOLOGY

The Delaware Society for Clinical Oncology has been in contact with Senator Roth's office with regard to proposed reductions in Medicare payments for chemotherapy services furnished to cancer patients. We believe that the proposed cuts will severely impair the ability of oncologists to treat cancer patients in their offices.

The Delaware Society for Clinical Oncology has also expressed ob-

jections to the Hyde-Nickles Pain Bill, which has passed the House of Representatives and the Senate Judiciary Committee. The Act is designed to prevent assisted suicide, but we believe it will have a chilling effect on physicians prescribing narcotics for relief of cancer pain.

Our Society has been sponsoring a monthly CME lecture series on a variety of oncology topics with nationally known speakers.

Steven C. Falchuk, M.D.
President

The report was filed.

DELAWARE SOCIETY OF INTERNAL MEDICINE

I am pleased to report that the merger of the American College of Physicians and American Society of Internal Medicine has been completed on a national level. The merger of these two organizations presents a unified voice for internal medicine in educational, academic and public policy matters.

The end of 1998 should complete the merger of the local organizations. It will then be called the Delaware Chapter of ACP-ASIM. The combined organization will continue to be an effective voice for internal medicine and its subspecialties.

John F. DeCarli, D.O.
President

The report was filed.

DELAWARE CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

As of July 1, 1998, the American College of Physicians and the American Society of Internal Medi-

cine have merged into one organization known as the ACP/ASIM. The Delaware Chapter of the ACP/ASIM is quite pleased that John DeCarli, D.O., has been appointed an interim Governor of the new organization for one year. John is also the Chair of the Health and Public Policy Committee of the Delaware Chapter.

The Annual Scientific Session of the Delaware Chapter was held on February 22, 1998, at the Christiana Hilton with a final attendance of 100. The program was quite ambitious, with three lectures and two workshops highlighted by the College Representative, Michael LaCombe, M.D., FACP. The Leonard P. Lang Award was presented to Helen Ting, M.D., and the Laureate Award to Mansour Saberi, M.D., FACP.

The Delaware Chapter continues in its educational endeavors with Internal Medicine Mentoring in Kent and Sussex Counties under the guidance of Drs. T. Noble Jarrell and Mansour Saberi. Twice yearly we sponsor a Residents' Club with the general theme of Medicine and Ethics. Finally, the Delaware Chapter is also quite active in matters of health and public policy. John DeCarli, D.O., FACP, and Chuck Esham, M.D., FACP, represented our Chapter in Washington and discussed matters pertinent to Internal Medicine with our Senators and Representative.

Joseph A. Kuhn, M.D., F.A.C.P.
Governor

The report was filed.

DELAWARE CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons has had an active year focused on three broad fronts, the

first of which is the scientific area. In that regard, the state chapter held their annual scientific symposium at the Delaware Academy of Medicine on Saturday, October 25, 1997. The topics included colorectal cancer, breast cancer and prostate cancer.

The second main thrust of our activities had to do with the socioeconomic issues facing surgeons not only in our state but nationwide. To that end, we sent a delegation to Washington, D.C., consisting of Dennis R. Witmer, M.D., F.A.C.S.; Rafael Zaragoza, M.D., F.A.C.S.; and Shah Morovati, M.D., F.A.C.S., to meet with key congressional delegates from Senator Biden's office, Senator Roth's office and Representative Castle's office.

Our third area of activity was social. The Chapter's annual dinner-dance was held on the evening of Saturday, October 25, 1997, at the Wilmington Country Club and featured an art exhibit by physician surgeons who displayed works of original oils, water color, sculptures and photography. This was followed by dinner and dancing on into the evening.

In the future, our efforts will be continued toward these three broad areas. This year's scientific symposium will be held Saturday, November 14, 1998, at the Delaware Academy of Medicine and will be focused on minimally invasive techniques of surgery and management of their complications.

Dennis R. Witmer, M.D., F.A.C.S.
President

The report was filed.

AMERICAN COLLEGE OF NUCLEAR PHYSICIANS

This is in reference to the activities of the American College of Nuclear Physicians for the year 1998. One of the major changes occurring in the government to affect the practice of nuclear medicine has been the rewrite of 10 CFR part 35, the medical use of byproduct material, and NRC form 314 application for material license and supplemental forms, also, application 313 A training and experience and preceptor statement. In response to concerns of several agencies within and outside of the government, the Nuclear Regulatory Commission (NRC) has undertaken a complete rewrite of part 35. Mainly this has to do with the control of radiation as it affects the environment, the population at large, and patients. The ostensible purpose of the rewrite was to reduce paper work and inconsequential activities that do not affect the health and safety of the population or have any effect on the environment. While the general purpose of this change is laudable, there are many problems fraught with the specifics of the change and whereas our College response to the rewrite contains over 40 items of concern, I will mention only those that we consider most significant and of greatest concern.

Of course, the overall difficulty has been the fact that the interposition of NRC regulations has a strong influence on the practice of medicine and we have been attempting to remove the NRC from the practice of medicine and restrict them to just the control of radiation safety and environmental protection.

One of the more contentious problems in the proposed legislation is the criteria of training in radiation safety and protection which

has become inexorably entwined with medical experience and clinical judgment and, therefore, looked upon with a great degree of variability from the different segments of the medical community commenting on the proposal. This continues to be a source of friction between the different medical groups concerned with the use of radioactive isotopes in their practice. Another matter of great concern to the College has been the level of control over the preceptor period of training. In many instances this has degenerated into a perfunctory exercise in paperwork, while in many other instances this is truly a learning experience. The other concern of the NRC has been the documentation of the level of activities in different nuclear medicine laboratories; this documentation in many instances has become redundant, superfluous, and serves no reasonable relationship to protecting the environment or the general public at large. While many procedures are being modified and a few are being eliminated, there still remain a great number of procedures and quality control activities that serve little or no purpose.

Another major area of concern is the recent adoption of new regulations by HCFA. These regulations were originally entitled APGs and are now called APCs and were originally meant to classify outpatient laboratory costs on the basis of cost experience in various facilities to apportion these costs to the various studies. Not only has there been concern about cross referencing of different studies because of incomplete data collection, but the government saw fit to attempt to bundle many outpatient procedures into one category and establish a single reimbursement for that category regardless of the type of studies

involved or the cost of producing these studies. Through extensive lobbying effort, some of the activities have been realigned so that more groupings are available and, thus, a more reasonable breakout of the costs involved. However, in the original straw man proposal, all of ultrasound was to be incorporated into one group and paid at one value regardless of what type of study was carried out. These proposals, which were to go in effect on the 1st of January 1999, fortunately, have been postponed one year. This type of legislation, if allowed to go on unchallenged, will produce significant alteration in outpatient activities, but these types of constraints are being proposed for all outpatient activity no matter what its origin.

On the brighter side, Congress recently approved some twenty-two million dollars for the development of the beam spur at the Los Alamos Laboratories. This will allow the United States to produce basis isotopes and research isotopes, which it has not been doing for about the past decade. This has been particularly significant when there are problems in the countries of our suppliers and our sources of basis isotopes then become curtailed. We can only hope that the government continues to exercise the necessary vision required to maintain adequate research in the field and allow development to continue unhampered.

Robert L. Meckelnburg, M.D.
President

The report was filed.

REPORTS OF LIAISONS AND REPRESENTATIVES

DELAWARE HEALTH CARE COMMISSION, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

The mission of the Delaware Health Care Commission is: *To promote basic, affordable, equal quality, accessible health care for all Delawareans.* Key objectives of this Commission are as follows:

Cost: Provide a regulatory and financial framework to manage the affordability of health care.

Access: Provide for equitable access to health care for all Delawareans

Quality: Develop a comprehensive health care reform package insuring quality health care for all Delawareans.

Education: Develop and implement educational programs for all aspects of the health care agenda.

During the past year the Delaware Health Care Commission has been working in a variety of different ways to accomplish its mission and fulfill these key objectives.

One of the most resource intensive and time-consuming responsibilities of the Commission is to assist the legislative and executive branches of Delaware government in matters regarding health policy. This occurs basically in two ways:

1. Respond to administrative efforts in the health care arena.
2. Review legislation that has been developed to address problems in this area.

Both policy and law are evaluated on a regular basis by the Commission and positions either taken, or not, depending upon the Commission's assessment of the relevancy and merits of each proposal. These positions are then shared with responsible administration officials or legislators who have committee jurisdiction over these issues. The Commission prides itself on being a non-partisan body that reviews proposed regulations and legislation and makes recommendations based on the merits of the proposals and the impact such proposals may have on Delawareans.

The Commission has also undertaken a number of initiatives under its own direction which are designed to help it address its strategic goals and fulfill its mission. These include, but are not limited to, the following:

1. Cost Shift Evaluation Committee
2. Delaware Health Information Network Committee
 - A. Executive Committee
 - a. Technology Committee
 - b. Policy and Procedure Committee
3. Educational Symposia
4. Administration of DIMER
 - A. DIMER BOARD
 - a. Rural Health Committee
 - b. Loan Interview Committee
5. Downstate Residency Rotation Program
6. Telemedicine Program
7. Diabetes Task Force
8. Individual Market Reform Committee

In all of these activities, and through a variety of forums, such as educational symposia, pilot demonstration projects, committee hearings, etc. the Committee attempts to obtain broad public input into the development of its policies and positions. The Commission truly represents a true public/private partnership that solicits your support and input as it strives to achieve its mission.

Joseph A. Lieberman III, M.D., M.P.H.
Member, Delaware Health Care Commission

The report was filed.

MEDICAL SOCIETY OF DELAWARE ALLIANCE

On February 27, 1998, the New Castle County Alliance held its tenth annual Gourmet Dinner and Wine Tasting, with 150 guests in attendance. The beneficiary of the event was the Westside Health Service. This program serves Wilmington Hispanic and minority communities. Dr. William Duncan, a special founder, friend, and contributor of Westside, was honored with a citation from the Delaware Legislature by the Alliance's own State Representative, Jane Maroney.

On April 23, 1998, the annual meeting for the New Castle County Alliance was held along with a Shelter Shower for Martha's Carriage House, a battered women's shelter in Wilmington.

On May 7, 1998, the M.S.D.A. held its annual meeting. The following took office: President - Elaine Bradley; President-Elect - Llyn Balakhani; Treasurer - Jane Henderson; Secretary - Katherine Pando; Vice President - Sue Saliba; Corresponding Secretary - Rosalia Ford. Martin Begley, M.D., President-Elect of the Medi-

cal Society of Delaware presented the Medical Society of Delaware Alliance with a check for \$3,500 for our upcoming year.

On May 21, 1998, the M.S.D.A. Executive Committee met at President Elaine Bradley's home for a planning session. The Board of Directors meetings have been set as follows: September 17th, January 21st and March 18th. The Semi-Annual Meeting will be November 21st.

On August 26, 1998, the M.S.D.A. organized a night at the Blue Rocks for all M.S.D. and M.S.D.A. members, family and friends. This was a fund-raiser for the Medical Society's Delaware Medical Education Foundation. All three counties participated by donating a basket in which raffle tickets were sold to help in the cause. A check for \$350 was presented at the picnic to Dr. Janice Tildon-Burton, Chair of D.M.E.F.

On September 17, 1998, the first M.S.D.A. Board Meeting was held at the Blue Coat Inn, in Dover. Three quarters of the board members attended. A presentation was given by Mr. Sherman Townsend, chairman of the D.I.M.E.R. Program. The M.S.D.A. annual meeting date was set for May 13, 1999. It was also decided that we will return to our original practice of installing State and County officers at this meeting.

On September 18, 1998, the M.S.D.A. assisted the M.S.D. members Drs. William Shellenberger, David Platt and Robert Frelick at Beach Day 98. We were called upon to man the M.S.D.'s exhibit from 10 a.m.-3 p.m. M.S.D.A. volunteers Sue Saliba, Kay Hosmane and Elaine Bradley assisted in handing out health information pamphlets and engaged in friendly conversation with the Seniors of our state.

October is AMAA National S.A.V.E. month with October 14th designated as National Save month. Again this year our three counties have been asked to host shelter showers in their communities to help the homeless and victims of domestic violence.

Kent County Alliance will be hosting a welcoming coffee and shelter shower for the Shepherd Place on October 29th at Wild Quail Country Club. Mr. Michael P. Lovett, program director of the Shepherd Place, will be speaking about the shelter and will answer any questions we may have.

As a Health Project, K.C.M.S.A. in cooperation with the Delaware State Troopers' Association of Troop 3 will be embarking on a Bicycle Helmet Safety Program. The troopers refurbish used bicycles to give out to the poor children in rural Kent County. We will be helping by providing funds so that a helmet can be given along with the bicycle.

The Sussex County Alliance's primary concern this year is with the issue of Domestic Violence. They have been providing the state with the Family Violence Hotline Cards. These cards are being distributed in all three counties. They plan to go into the schools to teach the small children ages 3-5 about the "hands are not for hitting program." They draw their hands on the hands are not for hitting placemats and then they discuss other ways that our hands can be used. This is an AMAA initiative. They will also be distributing the "Don't Shake the Baby Leaflets" in Beebe Hospital and throughout the community.

The Sussex County Alliance has been successful in holding monthly meetings since September '97 with sufficient attendance.

On November 21, 1998, the Spouses Program will again be held in the Greenville Suite of the Hotel duPont. The program will be as follows:

8:30 - 9:30 a.m.

Coffee and Conversation

9:30 - 10:00 a.m.

Brief State and County Reports

10:00 - 10:30 a.m.

Guest Speaker - Katherine Kolb, Perinatal Association of Delaware

10:30 - 11:00 a.m.

Guest Speaker - Representative Jane Maroney

11:00 - 12:00 Noon

Hotel DuPont's Chef Tom Hannum - featuring Heart Healthy Holiday Fare

Elaine Bradley
President

The report was filed.

LEGISLATIVE SPECIALIST

The second session of the 139th General Assembly adjourned in the early morning hours of July 1st after a flurry of activity.

In January, it appeared as though the session would be slow and quiet. The main issues were education (accountability), the size of the surplus, and what size tax cut and spending package would be finalized.

By June the surplus was at \$450 million, the education issue was still being negotiated, and a reduction of property taxes increased partisan bickering.

In April the Republicans presented a proposal that would eliminate the school property tax in 20 percent increments over five years, at which time the state would assume 100 percent funding for

education including new school construction. There seemed to be very little support for this proposal, mainly because the ramifications could not be determined. As of now, the state's share of education funding is 70 percent and the local district is 30 percent. New school construction is 60 percent state and 40 percent local districts.

Just before midnight on June 30th an agreement was finally reached and both the Senate and House passed the financial package of bills by early morning of July 1st. The final tax package included: a personal income tax (P.I.T.) cut set at 6.4 percent (down from 6.9 percent) for those individuals making \$60,000 and above and 5.9 percent for those individuals making under \$60,000. Additionally, 27,000 low income individuals were dropped from the tax rolls. A Gross Receipt tax proposal was adopted (manufacturers), inheritance taxes were eliminated, and the pension exclusion was raised from \$3,000 annually to \$5,000. Furthermore, \$48 million was set aside for a committee to study the feasibility of a reduction in school property tax.

In the health care area, the Medical Society of Delaware had a busy but rather successful session. Of particular note was the defeat of HB 650. This legislation would have opened up the statute of limitations for medical malpractice actions. The Society came together as one in response to the legislative alert, with phone calls and personal contacts by physicians to Senate and House members and excellent testimony when the bill was being debated by Society President Stephen S. Grubbs, M.D. This certainly helped ensure the bill's defeat.

The General Assembly later approved House Concurrent Reso-

lution No. 94, which establishes a task force to review the medical negligence statute of limitations and related issues. The President and President-Elect of the Society or their designees will serve as members of the task force.

SS1 for SB 194 (Blevins), the "due process bill" introduced at the request of the Society and signed by the Governor, requires a managed care company that proposed to terminate or not renew a contract with a professional health care provider to give a minimum of 60 days written notice and to include notice of the provider's right to request a written explanation and internal administration review within 20 days.

SB 339, the pharmacy bill, did not pass in its original form. With input mainly from the Society, a compromise substitute bill was passed late in the session. The original bill would have expanded pharmacists' services to include giving injections for flu shots and childhood immunizations, as well as taking blood for purposes such as blood sugar testing. The pharmacists argued that this bill would improve consumer access to health care. The Society voiced opposition due to the lack of patient safeguards, and because of concerns about children being taken to the pharmacist for injections instead of the physician for childhood examinations. The compromise bill limits injections to adults with a prescription or physician-approved protocol. The scope of the protocol or valid prescription must be limited to that physician's patient population. In addition, a Pharmacy Regulatory Council of the Board of Medical Practice will set the requirements and guidelines necessary for pharmacists administering the injections.

HB 673 (Oberle) adds a representative designated by the Medical Society of Delaware to the Workers' Compensation Advisory group that consults with the Department of Labor.

Other health-related legislation:

SB 396, accountability of medical reviewers, was introduced by Senator Sokola at the request of the Society in order to provide accountability under medical review similar to that in Texas. The bill was introduced late in the session and was not worked. This will be a priority in the next legislative session.

HB 580 (Buckworth), to facilitate organ and tissue procurement, was amended so that it satisfied physicians who were initially concerned about the doctor-patient relationship. The bill has been signed by the Governor.

SB 325 (Blevins) "the telemedicine bill," would have provided for the issuance of a special purpose license. Because of a lack of consensus and because of objection by the managed care companies regarding application of the requirement to medical directors, the legislation did not come up for a vote.

SB 225 (Henry), to establish a needle and syringe exchange pilot program in Wilmington. The Society supported the pilot program but the bill did not come up for a vote because of the lack of sponsors.

HB 211 (Buckworth), the "partial-birth" abortion bill, would have banned this procedure except to save the life of the mother. The Society's amendment eliminating the criminal penalty was accepted prior to passage by the House.

The Senate amended the bill, but it did not come up for a vote in the House.

HB 566 (Maier), relating to mandatory testing of pregnant women for HIV passed the House but did not come up for vote in the Senate.

These are just some of the bills relating to health that grabbed our attention in the past session. If you would like copies of these or other bills, please call the Society. No doubt there will be issues that will warrant our attention during the new 140th General Assembly convening the second Tuesday in January 1999.

This new General Assembly will see some new faces because of retirement and/or winning an election on November 3, 1998. However, it doesn't look as though any changes of majority caucuses, will occur. The House Republicans and Senate Democrats will hold their majorities in their respective houses.

This year there were five veteran legislators who retired: four Republicans, Representatives Maroney, Petrilli, Mack and Senator Hague, and one Democrat, Senator Voshell.

The Society also introduced a resolution commending Representative Maroney for her tireless efforts in the health care field, especially for children, and also being a good friend of the Society. This was expressed on the House floor during the passing of this resolution. We certainly wish her all the best.

Philip J. Corrozi
Legislative Specialist

The report was filed with a commendation to Mr. Corrozi for his excellent work this past year.

PHYSICIANS EMERITUS OF DELAWARE

The Physicians Emeritus of Delaware meets three times a year and in 1998 met in January, April and October. The meetings are preceded by a social hour followed with lunch and a speaker.

This year, Dr. Ali Hameli spoke on his experience in the Mengele case in Brazil. Next, Dr. Arnold Kerr told of his experiences in World War II, becoming only one of the survivors in his Jewish family from Poland. Lastly, Mark Meister, our Executive Director, discussed "Is your physician at the helm or adrift in a sea of health care coverage?"

We continue to encourage members to donate their literary efforts and/or works of art to the Academy of Medicine. Recently, Dr. David V. Pecora and his wife, Dorothy, donated their book on World War II experiences as physician and nurse titled "Between the Rain Drops."

Wives, widows, husbands and widowers of members are encouraged to attend our meetings, which regularly attract 50-75 participants.

Davis G. Durham, M.D.
President

The report was filed.

WEST VIRGINIA MEDICAL INSTITUTE (WVMI)

The Health Care Financing Administration (HCFA) awards PRO contracts for three year periods called scopes of work. The current 5th scope of work is scheduled to end in Delaware on July 1, 1999. In August 1998, a preliminary draft for the 6th scope of work

was made available, and both continuity and changes are in the air. PROs will continue the improvement projects and the very limited chart review in specifically mandated areas. Outreach activities to beneficiaries will continue as long as they are congruent to the 6th scope of work goals. Three changes include the PROs adopting a systematic approach to program integrity, quality assurance criteria will be included in all PRO activities, and specific PROs will be rewarded for superior performance on health improvement projects.

1. There are six National Improvement Projects: AMI, CHF, Pneumonia, CVA/TIA/Atrial Fibrillation, Diabetes and Breast Cancer. Each disease has quality and outcome indicators. For diabetes the quality indicators are the rate of retinal exams, HbA1C testing, and urine microalbumin testing. Outcome indicators are mortality at one year, and rates of development of retinopathy and ESRD. PROs will be given flexibility in choosing which projects to do with an emphasis on selecting ones that stand a greater than average chance of improving care or ones which focus on vulnerable populations. A broad range of care settings should be addressed, including offices, hospitals, perhaps a dialysis center, and possibly a nursing home. Each PRO will have to do one or more studies using the six national studies, and at least one other study of Medicare beneficiaries with a clinical condition other than one of the national six. For whatever studies the PRO does, it would have to use quality indicators and show improvement of the target population.

2. Payment Error Prevention Program (PEPP). This is a new activity HCFA is evidently mandating that PROs consider. The PRO "shall identify fraud, waste and abuse" and so shall reduce the percentage of Medicare dollars which should not have been paid. The PRO is to identify trends or patterns that may be suggestive of "inappropriate, unreasonable or unnecessary care" and coding issues would be addressed. If unreasonable, unnecessary, or substandard care is identified, the PRO would propose interventions starting with provider education and improvement processes, but could also include a referral to licensing or accrediting bodies or the OIG. The PRO is required to collaborate with the fiscal intermediary on a pilot project, and activities in this arena would generally be limited to 10 per cent of the PRO budget for PEPP activities.
3. Mandatory chart review activities would continue in a somewhat similar vein. Beneficiary and dumping complaints, assistants at cataract surgery, hospital requested higher DRG validation, notices of noncoverage, and certain referrals would prompt a specific chart review. If PEPP activities found a potential problem, additional chart review might be done.
4. More structured requirements for the PRO to communicate with providers have been proposed.

The changes in the draft proposal for the 6th scope of work have both positive and negative implications. In the plus column is the continued focus by the PROs on looking at patterns of care and

having providers compare their care with national benchmarks. There is a trend away from just looking at what happens to inpatients and as less care is being given in the hospital, this is necessary if you are to look meaningfully at improving outcomes. The main piece of the 6th scope of work in the negative column is HCFA's increasing emphasis on "fraud and abuse." This will occur with or without the PROs; however, if the proposed draft for the 6th scope of work is not changed, the PROs will have to become at least somewhat involved in this arena.

Some PROs including WVMI are concerned about the fraud and abuse mandates as they have built up a positive relationship with many in state providers. The focus on the very rare "bad apple" could jeopardize the relationship WVMI has nurtured with both Delaware and West Virginia physicians. HCFA is aware of these concerns. However, if HCFA decides that the fraud and abuse question must be given greater scrutiny, a PRO with credible, practicing physicians in the loop is important to have. I know that WVMI has always been sensitive to the challenges facing practicing physicians, and regardless of what happens, this will continue.

In Delaware HCFA has announced that it will release for competitive bidding the contract for the 6th scope of work. WVMI will aggressively bid for the contract, and other PROs have expressed a strong interest in doing likewise. If a PRO can be considered an in state organization, it is allocated extra points in HCFA's bidding evaluation process, and so such an organization has a higher probability of being awarded the contract. Consequently, several organizations including WVMI have approached the Medical Society with proposals so they may be considered a local organization. To prudently

evaluate these propositions, the medical society appointed an ad hoc committee. This group is having ongoing meetings with the interested parties, and in the near future soon should reach a consensus as how to best proceed.

Brett Elliott, M.D.
Trustee, WVMI

The report was filed.

YOUNG PHYSICIANS SECTION

The Medical Society of Delaware's Young Physicians Section (YPS) has now completed its first year of activity. The mission of the YPS is to identify and address the needs, common problems, issues and interests of Delaware's young physicians and to provide a forum for the exchange of ideas and information. The YPS promotes increased participation by young physicians in all levels of organized medicine via assignment of members to all MSD committees, representation on the MSD Board of Trustees and House of Delegates, and representation in the AMA.

All members of the MSD who have been in practice five years or less, or are under 40 years of age, are automatically members of the YPS with no additional dues requirement. The YPS now has over 300 members. The YPS is governed by the representative assembly comprised of YPS representatives from Kent, Sussex and New Castle County Medical Societies.

The YPS's first year's activities have been focused on facilitating communication among Delaware's young physicians, increasing young physicians' participation in the MSD and increasing continuing medical and practice management educational opportunities. The Section has had four special events which have addressed physician financial

planning, an introduction to the services offered through the Society's Physicians' Advocate office, Patients and Workers' Compensation and organizational issues. The YPS Assembly has monthly conference calls to conduct business and to facilitate communication. YPS members have been appointed to all MSD committees and are active on the Board of Trustees.

The YPS's goals for its second year of activity include a continued and active presence on MSD committees, further development of educational/social events concerning practice and medical management, and increased involvement of young physicians in the state political process as it affects public health and health care.

Finally, I would like to thank the YPS Assembly members who have volunteered their scarce time to build a strong foundation to further develop the section: Doctors Thomas P. Barnett, Evan H. Crain, David E. Driban, Kelly S. Eschbach, David Islam, Neil S. Kalin, Carey L. Nathan and Vincent J. Perotta; Mary LaJudice of the MSD staff, for her enormous amount of work in organizing and performing the critical daily functions of the section (without her, the section would not exist); and Mark Meister and Stephen Grubbs, M.D., for their continuous guidance and opportunities provided to Delaware's young physicians.

Our Young Physicians Section looks forward to another year of growth and assisting our Society serving Delaware's physicians and patients.

Michael S. Katz, M.D.
Chair

The report was filed with special commendation to Dr. Katz for his excellent leadership of the newly founded Young Physicians Section.

REPORTS OF ADVISORY COUNCILS

ADVISORY COUNCIL FOR CANCER CONTROL

The Advisory Council for Cancer Control was initiated about ten years ago by Delaware's Division of Public Health. It was composed of individuals representing the professional background of agencies interested in Cancer Control throughout the State such as the Medical Society, Delaware's Chapter of the American College of Surgeons, Delaware Society for Clinical Oncology, the American Cancer Society, the State Hospital Association, the Department of Natural Resources, the Division of Aging, the Cancer Registrar's Association, BNREC, and the University of Delaware's College of Nursing. Unfortunately, instead of using the Council to stimulate collaboration between those interested in Cancer Control, it soon became an Advisory Council to the Division of Public Health for such items as the Mobile Mammography project.

Recently the Council has very actively been involved in outlining ways to stimulate cancer control based on several studies required by the Legislature to reduce the burden of cancer in Delaware. It has been easier for the Legislature to ask for studies than to act on the recommendations, so that the Advisory Council has been investigating how to implement many of the results of the studies.

Therefore, in the last year, the Council has explored the value of expanding to become a broader coalition of parties involved in cancer control staffed by the Division of Public Health. This recognizes there are many prevention and screening programs which

are equally important for the control of other chronic diseases such as cardiovascular and metabolic diseases. Common efforts to reduce the use of tobacco through IMPACT, with financing from CDC within the Division of Public Health, the Cancer Society and the Delaware Associations for the Heart and Lung, have emphasized the importance for cooperative, collegial, educational, and administrative activities to improve local resources for controlling cancer as well as many other chronic diseases.

Currently the Council is waiting for the public health staff to explore ways to develop the wider coalition the group had agreed upon. Presumably that is waiting for the new leadership of the Division of Public Health coming on board in the middle of October.

Robert W. Frelick, M.D.
Liaison

The report was filed.

CONTROLLED SUBSTANCE ADVISORY COMMITTEE

As 1997 ended, it was obvious that Percodan was being misused by diversion and that Ketamine needed a system of control. Some control was gained through the scheduling of Ketamine, Schedule III; Rohypnol was assigned to schedule IV. These subjects were under review this year and are still being considered.

Resolutions concerned with management of heroin appeared in both the House and Senate of Delaware's General Assembly. House Resolution 76 passed with suggested duties to review cycles of drug abuse related crimes and submit recommendations to the House by April 30, 1999.

Drugs on the street in excess use have been cocaine and crack, methamphetamine (speed), LSD, marijuana, Ritalin, Ketamine and GHB (gamma-hydroxybutyrate)

AmeriHealth Insurance Company informed their medical providers that all prescriptions must carry each physician's DEA identification number. This was soundly rebutted by the special agent of the US Departments of Justice Drug Enforcement Administration's Philadelphia Field Division. It was pointed out that the Health Care Finance Administration (HCFA) is dealing with the problems, and all physicians across the country will be assigned special identification numbers for payments in the future. HCFA suggests that all physicians continue to protect their DEA numbers.

Mrs. Ann Carter of the DEA pointed to oxycodone (i.e. Percocet), hydrocodone (i.e. Vicodin), alprazolam (i.e. Xanax) and codeine cough syrups. Delaware's medical examiner's autopsies show the abused drugs as crack (45 percent), marijuana (32 percent), heroin (11 percent) and cocaine (46 percent).

Legislation of concern in the future is the continued defeat of Senate Concurrent Resolution 78 that would suggest a totalitarian type committee to first "act only on heroin" – what will be next?

On October 6, 1998, a revamping of regulations in the use of Methadone in desensitizing clinics was revealed to the Controlled Substances Committee. The government in reacting to a complaint that Methadone therapy was restrictive as no other therapy (diabetes, hypertension, arthritis, etc.), placed, by regulations, Methadone in the hands of family physicians who would be certi-

fied as a qualification to treat addicts with Methadone. The certified physicians would report to a state-designated and certified authority. Furthermore, the certified physician could write open-ended prescriptions and no longer have the patient return for stipulated small amounts of Methadone while being fortified by frequent counseling in breaking their addiction habit.

Rhoslyn J. Bishoff, M.D.
Liaison

The report was filed.

DIABETES COALITION

About eight years ago the Delaware Division of Public Health recruited an Advisory Council for Diabetes at the request of Dr. G. Stephen DeCherney using the same model DPH had previously used for its Advisory Council on Cancer. The Diabetic Council met fairly regularly and among its other accomplishments published a Delaware Diabetes Resource Guide. In the last several years, questions were raised about how to make the Council more effective in efforts to reduce Delaware's unusually high death rates from diabetes and to limit the complications suffered by patients especially those who are not compliant with modern concepts of treatment. As a result, it was decided over a year ago to expand the concept of a Council to a Coalition more representative of the multiple disciplines involved in the detection and management of diabetes as well as lay representatives.

That group has reorganized, adopted a set of bylaws, and is now staffed by the Division of Public Health with the aid of funding from CDC, which also provides a modest budget for pro-

gram development. Currently the group is working on standards for diabetic care and has almost completed an update of its Resource Guide. A Medical Advisory Group is now being formed with Dr. James Lenhard, Dr. Mansour Saberi, Dr. Vincent Lobo, and Raelene Maser, Ph.D., from the University of Delaware. I am currently serving as the liaison between the Coalition and the Advisory Group.

This Advisory Group has been formed to assure medical oversight of the work being done by the Coalition. Since the group's meeting times are at inappropriate times for most practicing physicians, it has been elected to keep contact with the Medical Advisory Group through the minutes of the Coalition and through my attendance at the Coalition meetings. The Coalition standards based on those promulgated by the American Diabetes Association have already been reviewed by several of the group and will receive more review before being finalized.

Dr. Charles Laudadio was originally appointed by the Medical Society as its representative on the Council. Since he has moved to New Jersey, there has been no official tie to the Medical Society. Therefore, the Coalition has requested a Medical Liaison to the Medical Society, and I have been appointed to serve in that capacity by Dr. Stephen S. Grubbs. The Coalition meets in the Dover area from 8:30 to 10:00 a.m. on the third Thursday of the month.

Robert W. Frelick, M.D.
Liaison

The report was filed.

DELAWARE HEALTH RESOURCES BOARD

This report covers the period of October 1997 through September 1998.

The Delaware Health Resources Board was established by House Bill No. 331, signed into law by Governor Carper on June 22, 1994. The Board is comprised of 21 members, including a representative of the Medical Society of Delaware and other designated organizations and interests as well as nine representatives of the public-at-large. Certificate of Need (CON) decision-making authority is vested in the Board. Subsequent legislation has provided for the phase-out of the CON program, with CON scheduled to sunset entirely on June 30, 1999.

The Board has adopted a Health Resources Management Plan, the purpose of which is to "assess the supply of health care resources, particularly facilities and medical technologies, and the need for such resources." Given the rapidity with which change is occurring in the financing and delivery of health care, flexibility, as reflected by a set of general principles, is a critical aspect of the Plan.

Certificate of Need decisions by the Board follow:

Bayhealth Medical Center - Upgrade angiography unit at Kent General Hospital to perform diagnostic cardiac catheterizations - Approved.

Beebe Medical Center - Upgrade angiography unit to perform diagnostic cardiac catheterizations - Approved.

Surgical Associates of Delaware, LLC - Establishment of a single

specialty (ophthalmology) free-standing surgical center in Dover - Approved.

Christiana Care Health Services, Inc. - Construction of an ambulatory surgery center in Wilmington - Approved.

Christiana Care Health Services, Inc. - Replacement of cardiac catheterization equipment - Approved.

Beebe Medical Center - Acquisition of lithotripsy equipment for placement in Millsboro Surgery Center - Approved.

Beebe Medical Center - Establish a 10-station renal dialysis facility - Approved.

Bio-Medical Applications of Delaware, Inc. - Establish a 10-station renal dialysis facility in Rehoboth - Denied.

Steven L. Edell, D.O.
Liaison

The report was filed.

DOMESTIC VIOLENCE COORDINATING COUNCIL

This year, council activity closes with as many as 12 different sponsors presenting 16 different programs through the "Domestic Violence Awareness Month of October."

Action by the Council prior to October 1998 saw House Bill 510 developed to place domestic violence offenses in a single subpart of the criminal code. HB 510 did not make its way out of the House; thus, its intents will need reworking for future consideration by the next General Assembly.

The House did form a special committee to consider having Family Court an open court. The committee's final report is not available at this writing.

State election years seem to bring about changes, as has been the situation in the Domestic Coordinating Council. Our Executive Director, Raina H. Fishbaine, Esq., is moving into the Governor's Office, while her assistant, Jennifer Barber, Esq., replaces Michael Arrington, Esq., in Family Court. Not to be outdone by the supporting office, the Council has Gordon Reed, M.D., replacing Ann Aldridge, M.D., to assume her duties on the medical subcommittee. Lastly, at the September 30, 1998, meeting, a new post was created on the Council, namely, to accommodate a member to the Council from the Department of Corrections. This new addition will give us 15 voting members, which is considered a manageable voting number.

Subcommittees are productive. The Law Enforcement Committee promised monthly "Domestic Incident Report Statistics." These very helpful reports are in the chairman's office each month. This is one proof of the dedication of our members and their subcommittees.

Rhoslyn J. Bishoff, M.D.
Liaison

The report was filed.

FAMILY LAW COMMISSION

A group of very vocal citizens made the complaint, "Family Court is closed." This statement was followed with the suspicion that the Court had something to hide. The Family Law Commission responded with mixed opinions. Members of the House brought the vocal citizens' arguments to the floor of the House of Representatives. Again, there were mixed opinions. By creating an investigative committee, a compromise was struck. Investiga-

tors were charged to learn the creditability and advisability of open Family Court. Germane to this question is the judicial fairness to all judges of all Delaware's courts. Each judge may close any court when she or he deems it necessary to take such action. At this writing, I do not have the finalized report of the House's investigative committee.

Oddly, public complaints to the Family Law Commission during this year have been low in number. The focus on the national scene and the hope that the House's investigative committee report will satisfy concerns may explain this lull.

The Commission's in-house activities are worth noting. Change was the order of things. Judge James retired, and a committee was charged to select a suitable replacement among the judges of Family Court. Adding to this change was the addition of Henry DePhillips, M.D., as county representative, with Julia Pillsbury, D.O., moving out as county representative to be the Pediatric Academy's representative. Finally, adding to the change, Representative Jane Maroney is leaving the House of Representatives to be replaced on the Family Law Commission by Representative Gerald A. Buckworth of the 34th District, who will serve as chairperson of the Commission.

The Medical Society of Delaware, cooperating with the House of Representatives, witnessed a resolution highlighting all of Jane Perkins Maroney's accomplishments as she departs from the Delaware House of Representatives.

Rhoslyn J. Bishoff, M.D.
Liaison

The report was filed.

MEDICAL CARE ADVISORY COMMITTEE (MCAC)

I have been privileged to serve as the MSD representative to the MCAC again this year.

The MCAC is charged under federal regulation with being an advisor to the Medicaid agency director on matters of health and medical care services and is composed of representatives of the field of medicine, consumers, consumer groups and other fields concerned with health and medical care services.

During the year since my last report to the Society, the MCAC continues to be responsive to the needs of the Medicaid community. Activities of the Committee included:

Replacing Mr. Richard Ellis as the Hospital Association member with Mr. Joe Letnauchyn and expanding the committee to include a representative of the MCOs, Mr. George English.

Reviewing the Medicaid budget including new initiatives for children's dental care.

Reviewing the managed care program for Medicaid including the MCOs and problems with delivery of services especially mental health. A special meeting was held January 14, 1998, with the mental health providers and the MCOs to discuss concerns. Also reviewed were rates paid the MCOs.

Reviewing the RFP requirements for the next contract period for the managed care program, changes (including mental health language as a result of MCAC recommendations) and process for implementation of the next phases of the managed care program.

Looking at extensions of the managed care program to Long Term Managed Care (nursing homes), which is a very complex issue.

Reviewing the pharmacy program, including expansion, possible transfer to the MCOs, and coverage of medications such as Viagra®.

Learning about the redesign of the Division of Social Services to provide "one stop shopping/generic workers" concept.

Expanding eligibility for Medicaid to more uninsured Delawareans.

Reviewing the proceedings of the Health Care Commission and its implication to the Medicaid and uninsured programs.

Discussing the opportunities to improve the functioning of the MCAC to better meet the needs of the State and in getting input from the community on Medicaid health care matters.

In summary, this year has been a very busy year for the Medical Care Advisory Committee as health care has moved from the fee-for-service to managed care.

Edward R. Sobel, D.O.
Liaison

The report was filed.

SAFE AND DRUG FREE SCHOOLS AND COMMUNITIES ADVISORY COMMITTEE

Change in management of this committee is the order of the day. Edith Vincent is leaving her post. At the time of this writing, no successor to Mrs. Vincent has been appointed. Dr. Tom Butler will be the chairperson who will keep activities balanced.

The 1997 Delaware Department of Education Youth Risk Behavior Survey Report shows many areas that need to be reversed. The survey of the students for '97 gives these startling percentages:

- 22 percent rarely used a seat belt
- 30 percent carried a weapon
- 34 percent were in a fight during the year
- 10 percent attempted suicide
- 74 percent tried cigarette smoking
- 7 percent used chewing tobacco or snuff in the 30 days of the survey
- 77 percent had drank alcohol
- 49 percent used marijuana
- 8 percent used cocaine
- 55 percent had sexual intercourse in the past 3 months of this survey
- 53 percent used a condom during last sexual intercourse
- 42 percent had tried to lose weight; of those 7 percent used vomiting or laxative
- 37 percent attended PE classes at least once a week

When students were asked about their actions and life on school property the percentages were:

- 9 percent carried weapons on school property
- 5 percent did not attend school in the past 30 days because they felt it unsafe
- 8 percent had been threatened or felt unsafe on school property in the past 12 months
- 29 percent had property stolen or damaged
- 17 percent admitted to smoking on school property in the last 30 days; while 4 percent chewed tobacco on school property in last 30 days.
- 8 percent pointed out they used marijuana; while 6 percent had alcohol in the last 30 days all on school property

THE WORST STATISTIC OF ALL: 39 PERCENT HAD OFFERS OF GIFTS OF DRUGS OR DRUGS FOR SALE

The above would sound like failure, but it only suggests the need for more involvement and better methods of joining with our children in mutual understanding. Young people have revealed to us the problems and are asking contact to exchange thoughts and ideas.

Rhoslyn J. Bishoff, M.D.
Liaison

The report was filed. The Reference Committee highlighted what it thought was significant data in the report, which it believed painted an alarming picture of drug use and availability to children in Delaware. The Reference Committee recommended that the *Delaware Medical Journal* make this data available for a future article that, perhaps, could be shared not only with physicians but also with the parents of Delaware children.

DELAWARE SCHOOL HEALTH ADVISORY COMMITTEE

In the 12 months since our last report, the committee has met five times. Reviewed and improved to the satisfaction of all were concerns about student use of tobacco, controlled substances, weapons and alcohol. Athletic physical examination forms were approved for statewide implementation.

The increasing use of alternate medications, homeopathic drugs and over-the-counter remedies, all non-prescription, has created a dilemma for our school nurses. Parents bring or send with their children these remedies with directions from the parents (no physician endorsement) as to their

administration. The nurse has no guide to safely protect the student and herself when concluding her tasks.

Requirements for hepatitis B vaccine immunizations have been proposed to begin in the 1999-2000 school year for children entering day-care centers and 9th grade. In the school year 2000-01, children in kindergarten, 1st grade and grades 7-8 will meet the requirement. Finally, kindergarten through 12th grade will be completed with the three dose hepatitis B vaccination requirement by the year 2005.

At our final meeting on May 14, 1998, Mrs. Edith Vincent announced her retirement. At the time of this writing no announcement has been forthcoming of a replacement for Mrs. Vincent. She did such a thorough job with 100 percent dedication that they are probably finding it will take two or three persons to fill her position.

Rhoslyn J. Bishoff, M.D.
Liaison

The report was filed. Material that accompanied the report is available in the office of the State Medical Society (chart entitled "Relationship of the National Health Education Standards to the Traditional Health Content Areas and the CDC Adolescent Risk Behaviors" and State Board Education Guidelines for Administration of Nonprescription Drugs, Assistance with Medications on Field Trips, and Recommended Procedures to Follow for Controlled Substances).

REPORTS OF COMMUNITY HEALTH ORGANIZATIONS

AMERICAN CANCER SOCIETY, DELAWARE DIVISION

Tobacco:

The American Cancer Society has developed a smoking cessation and prevention program targeting pregnant women and mothers of young children. The program, Make Yours a Fresh Start Family, is designed specifically for use by health care professionals and technicians counseling on tobacco cessation. In the spring of 1998, eight master trainers were trained and will be training professionals starting in the fall of 1998. This program will bring about system changes for more effective tobacco control.

Advocacy Highlight for 1998:

Increased involvement and interest of ACS volunteers and staff in advocacy issues, demonstrating a stronger presence in the Delaware General Assembly. Legislators are aware that we are the resource for cancer control information.

A to Z Project:

The American Cancer Society and its Patient Service Department are proud to be part of the A to Z Project. The project was started in December of 1993 by the American Cancer Society and Zeneca, Inc. The project is a source for uninsured Delawareans to receive diagnostic breast testing; radiology and/or ultrasound. During our 1998 fiscal year the project received 176 referrals and three cases of breast cancer were diagnosed. Two major contributors of the project are The Breast

Health Institute, of Philadelphia, PA, and the Edgar A. Thronson Foundation, of Greenville, DE.

Prostate Cancer Awareness Campaign:

A prostate cancer awareness media campaign, targeted primarily toward blacks, was developed by the American Cancer Society and the Division of Aging. The program was launched in June 98 for Father's Day and used 19 DART outside bus cards in New Castle County, billboard, radio and guest editorials statewide. The message, "Have Your Prostate Checked, What you don't know can kill you," was combined with a photo of a black Wilmington doctor speaking to a black patient. Although no follow up was done to see if behavior changed as a result of the awareness campaign, the Christiana Care three-day prostate screening program in September reported a higher-than-ever participation by black men.

Leslie W. Whitney, M.D.
Liaison

The report was filed. The Reference Committee recommended communication with the downstate hospitals which are also involved with cancer screening.

DELAWARE CENTER FOR WELLNESS

The Delaware Center for Wellness (DCW) is primarily concerned with promoting preventive health programs in worksites. In the last year DCW has been operating under the handicap of a new Chairman of the Board whose communication with the Board, and the DCW staff has limited its activities. The Chairman's actions, presumably taken with the

best of intentions, stimulated merger discussions of DCW with one of several other agencies. The Board is in the process of asserting more direct control over DCW while merger negotiations have been underway with Christiana Care's PMRI (Preventive Medicine and Rehabilitation Institute).

Because of last year's loss of a major contract with a 3rd party payer, concern has been raised about the fiscal future of DCW. Measures to overcome that concern have been initiated, while there is hope that merger may reduce that concern.

The Board is hoping to preserve and expand DCW's ten years of quality preventive health services to Delaware Industries, but recognizes the need to find better ways to reach employees in small businesses. Most Delawareans work for small businesses and need to be stimulated to adopt healthy life styles to decrease risks of disease and injury.

In spite of the acknowledged importance of primary and secondary prevention, it has often been difficult, even in large workplaces, to find employers willing to support resources to maintain healthy workers although there is "evidence based" data to support the value of such an investment. Dues from industrial members of DCW are not enough by themselves to keep its program viable. Support from managed care organizations, which are required to promote prevention, has helped in the past as well as grants-in-aid from the General Assembly. Providing health risk surveys to help individual employees identify and undertake programs to reduce risks have been both a program benefit and a source of fiscal support to DCW.

It is recognized that most physician offices focus on treatment, and usually have limited time and professional staff to promote prevention. Therefore, it is important for the Medical Society to maintain relationships with those using evidence based preventive health programs to promote the adoption of healthy life styles through worksites.

On October 30, 1998, the Board of DCW approved negotiating the details leading to merger of DCW with PMRI.

Robert W. Frelick, M.D.
Liaison

The report was filed.

MEMORIAL

As a memorial to the members of the Society who were lost through death during the past year, the assembly rose for a moment of silence as the following names were read:

- John B. Baker, M.D. (SC) — a Past President of the Society
- Frederick Alton Bowdle, M.D. (NCC)
- Robert W. Buckley, M.D. (NCC)
- William J. Boyd, Jr., M.D. (NCC)
- I. Favel Chavin, M.D. (NCC) — a Past President of the Society
- V. Terrell Davis, M.D. (NCC)
- Emerson Y. Gledhill, M.D. (NCC)
- Alda G. Holliday, M.D. (KC)
- Stuart B. McMunn, M.D. (KC)
- Arthur A. Mencher, M.D. (NCC)
- Christos S. Papastavros, M.D. (NCC)
- Ruble C. Soule, M.D. (NCC)

ABSOLUTION RESOLUTION

The House adopted the following resolution:

RESOLVED, That each and all of the Resolutions, acts, and proceedings of the Board of Trustees of the Medical Society of Delaware heretofore had been adopted since the last meeting of the House of Delegates of the Medical Society of Delaware as shown by the records of the minutes and all the acts of the officers and trustees of the Society in carrying out and promoting the purposes, objects and interests of this Society since the last House of Delegates meeting are approved and ratified and hereby made the acts and deeds of the Medical Society of Delaware.

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Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting. (See Below)

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All advertisements are subject to approval by the Publications Committee of the Medical Society of Delaware.

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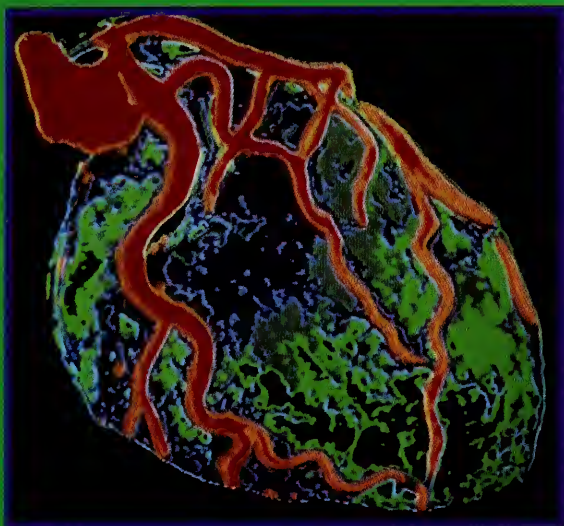
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7 A.M. - 3 P.M. ■ MBNA BOWMAN CONFERENCE CENTER ■ NEWARK, DELAWARE

Symposium Agenda

- **Fifty years of Framingham! What have we learned?** — William P. Castelli, M.D.
Framingham Cardiovascular Institute, Framingham, MA; Boston University School of Medicine, Boston, MA
- **Risk reduction therapy: the challenge to change** — Sidney C. Smith, M.D.
The University of North Carolina at Chapel Hill, Chapel Hill, NC
- **HDL and coronary heart disease: target for intervention?** — Daniel J. Rader, M.D.
University of Pennsylvania Health System, Philadelphia, PA
- **Heart break and heart disease** — Stephen T. Sinatra, M.D.
University of Connecticut School of Medicine, Farmington, CT
- **Heart disease and postmenopausal estrogens** — Trudy L. Bush, Ph.D., M.H.S.
University of Maryland, Baltimore, MD
- **Diabetes and heart disease** — M. James Lenhard, M.D.
Christiana Care Health System, Newark, DE
- **Hypertension – who and how to treat** — Joel Gellman, M.D.
University of Maryland and Baltimore VA Hospital, Baltimore, MD

Symposium chairman: Edward M. Goldenberg, M.D., Christiana Care Health System, Newark, DE

Registration

Call (302) 366-1825 for credit information and to register for this free symposium.

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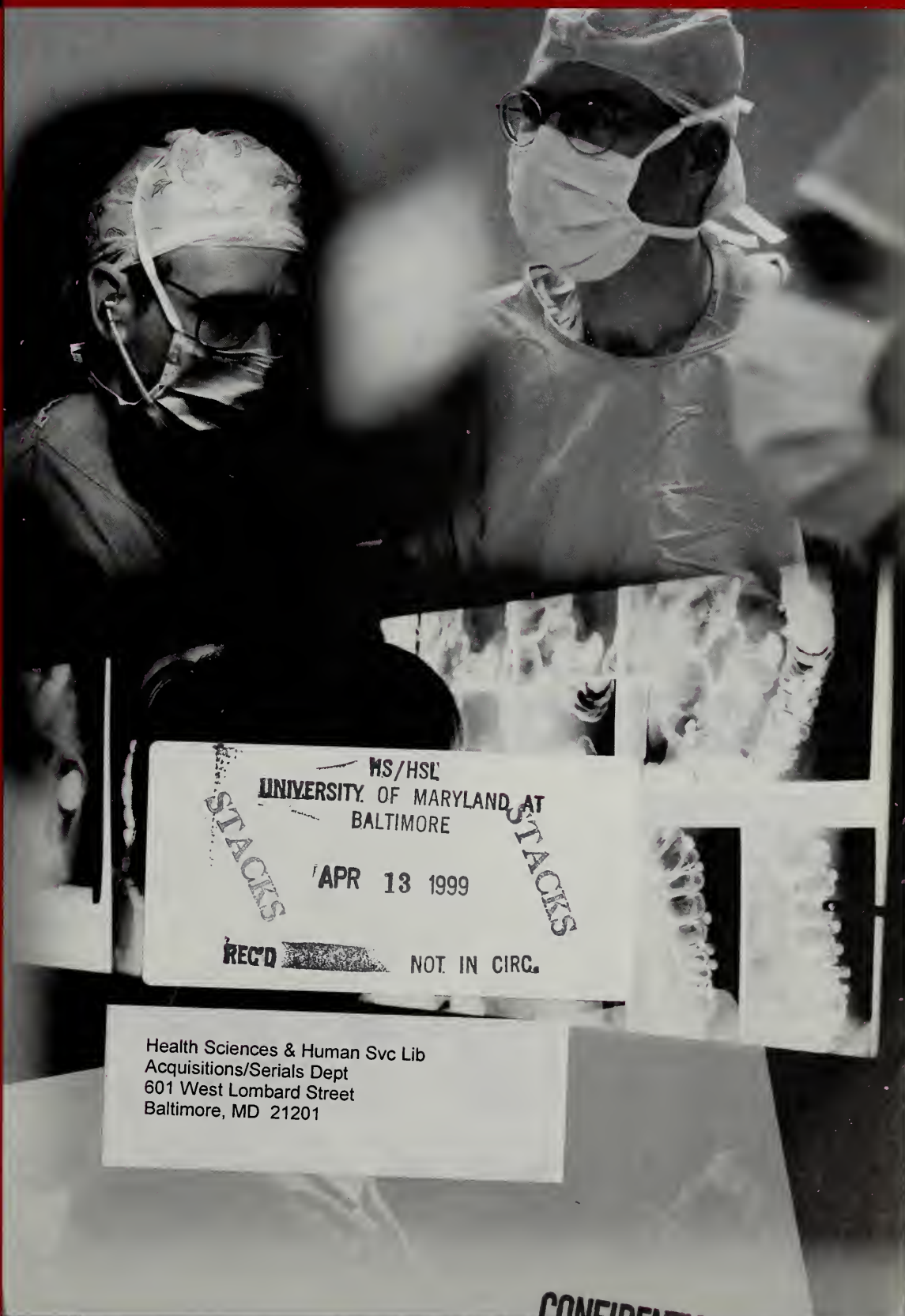
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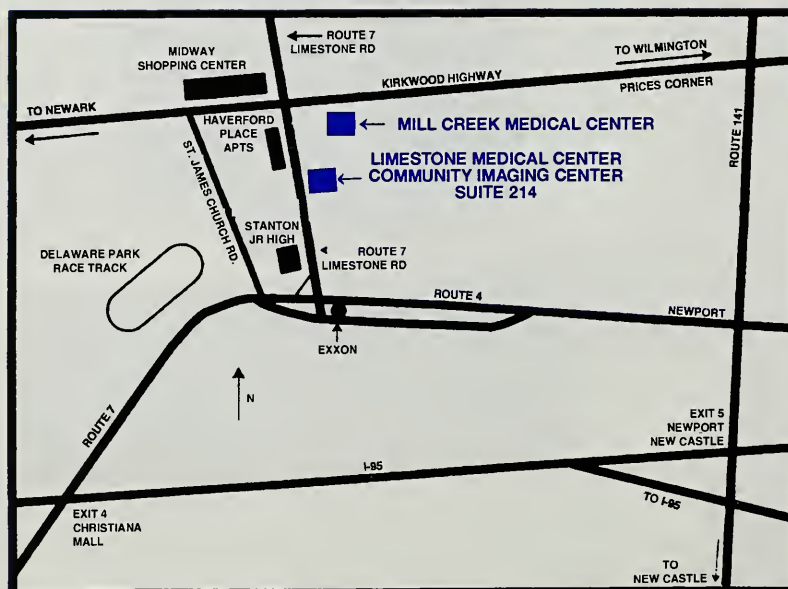
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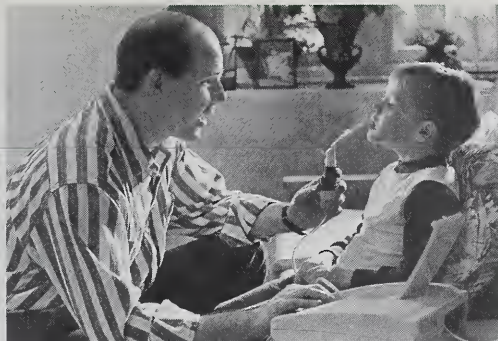
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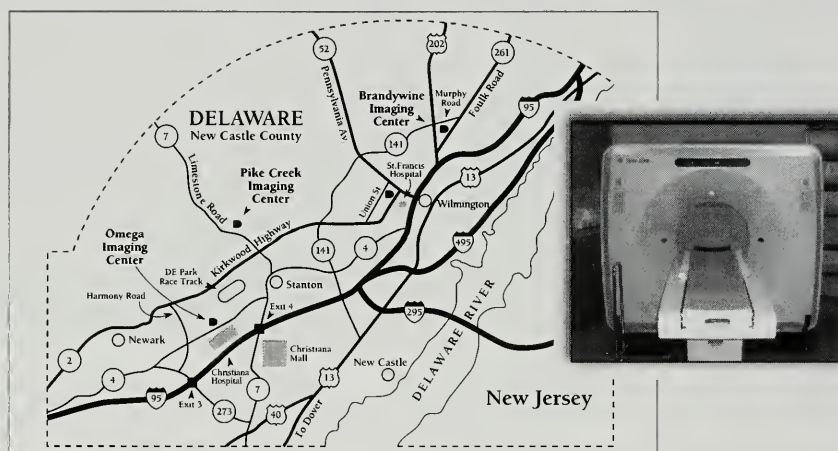
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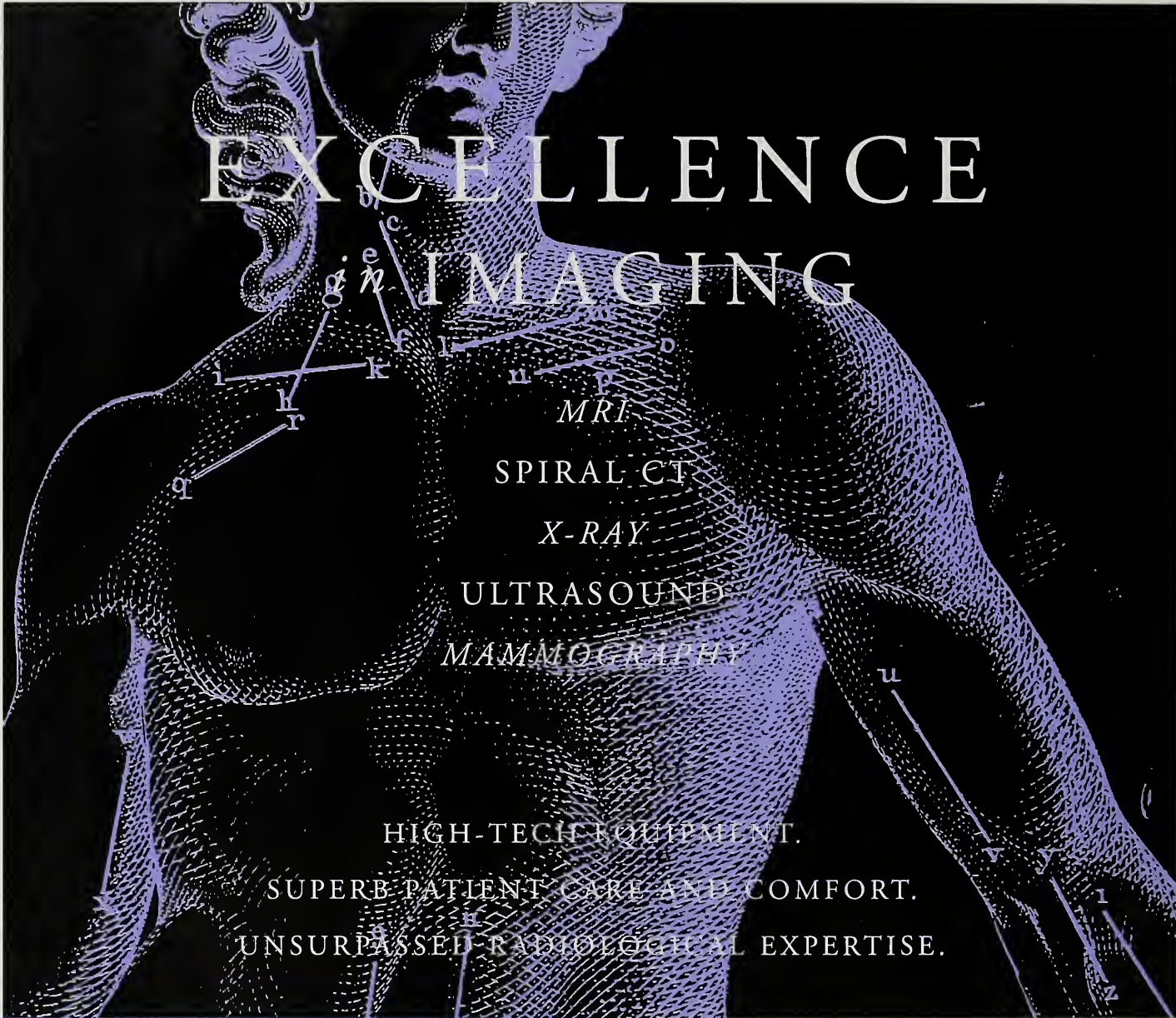
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What Has Happened to Medicine's (Society's) Most Basic Principle?

Martin G. Begley, M.D.



My late Uncle Dan O'Connor was a uniquely good man with a moral vision of our country extrinsic to health care today. He expressed that vision when we were watching coverage of the Korean War one frosty Saturday afternoon in the 1950s. Uncle Dan predicted, "We are going to lose this one." The way he saw it, the Chinese Communists had, "Millions of kids they'll feed to the cannon until they overrun us. They aren't like us. They don't believe that 'There is nothing more valuable than human life.'" Listening to him, I was really glad to be in this country, protected by a society that had such values.

Uncle Dan's observation was not that of a naïve man, for he had faced the cannon himself in battles throughout Europe during World War II. Uncle Dan was a man of principle. In fact, that's what got him into WWII. Faced with the Depression shortly after he emigrated from Ireland, he joined the Army because there, "You were sure to have a job and you wouldn't go hungry." When Pearl Harbor was attacked and the United States declared war, he re-enlisted even though he would have been immune from the draft due to his prior service and his age. He explained his actions by saying, "Uncle Sam was there when I needed him. Now he needs me."

High principle was innate to Uncle Dan's being and respect for the value of human life was right and natural for him as it was for most of his generation.

Physicians have preserved that value for our generation. I experienced this during my very first clinical rotation on the Surgery Service of District of Columbia General Hospital. There, we learned to care for people who were different from us; regularly presenting as dirty, hostile, and even combative. Often they were not very likable; sometimes they could be

repulsive. But we always "put on a full court press" to help them. Regardless of our differences, we were fellow human beings and therefore had profound intrinsic value. And over the days, weeks and, sometimes, months of caring for these patients, we recognized how we shared a kinship. Empathy and understanding replaced duty. We invariably departed as friends.

I am confident that all Medical Society of Delaware members have had a similar experience in training. We cherished life itself, then, and we still do! That's why we regularly find ourselves driving late at night to the emergency room to care for someone we don't know and who often cannot in any way compensate us for the care we give them.

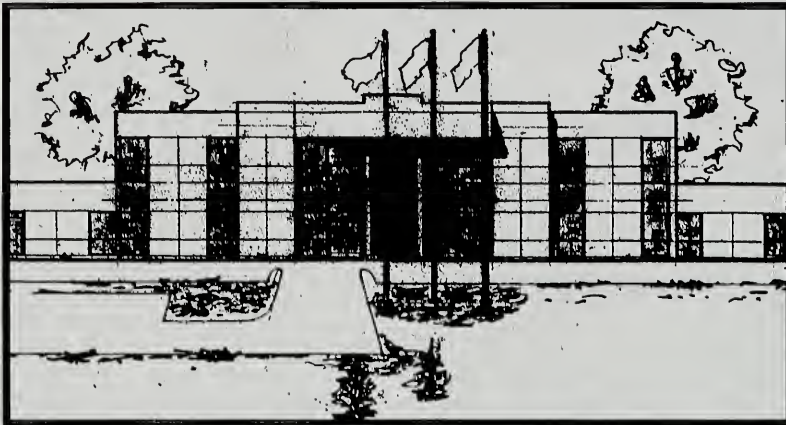
The problem is that this value of human life is lost in much of society outside of medicine. We can clearly see this in the almost three decades of debate concerning health care. During this time our industry and elected leaders have worried most about what might tweak the economy, trim corporate profits, erode CEO compensation, budge the standing of the dollar or shave corporate welfare. In the midst of this, no one has, as they should, screamed out, "What has happened to our respect for the value of human life?"

This question has to be asked. It won't be asked by number-crunching business types whose most profound moral guide is the ticker tape. The question must be asked by physicians who know the right answer, and who have lived for and by that answer. If we don't realize the answer generally, we will all be without the guiding principle essential for a civilized society.

A handwritten signature in dark ink, appearing to read "Martin G. Begley, M.D." with a stylized flourish at the end.

Martin G. Begley, M.D.
President

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, DE. He is the president of the Medical Society of Delaware.



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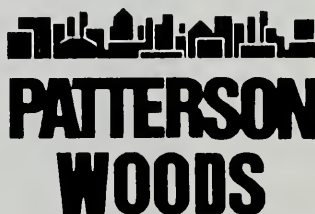
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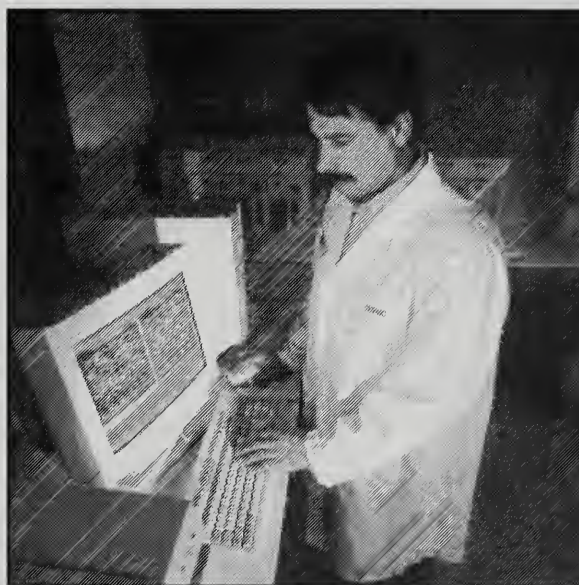


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Deputizing Patients: The Feds on the Attack

G. Stephen DeCherney, M.D., M.P.H.

By now, most of you have read that HCFA, through AARP, has authorized payment of a \$1,000 reward for any successfully prosecuted case of Medicare fraud by a physician or his/her office.

Rewards for Fraud and Abuse Information. The Incentive Program for Fraud and Abuse Information, which was also created under HIPAA, was implemented in July 1998. Under this program, rewards can be paid to Medicare beneficiaries and others who report fraud and abuse in the Medicare program. Their information must lead directly to the recovery of Medicare money for fraudulent activity, and the provisions can only apply for cases not already under investigation by federal or state agencies or Medicare's contractors. Rewards will be for ten percent of the recovered overpayment or a \$1,000 maxi-

mum, and will be financed from the collected overpayments.

Let me state at the outset of this editorial that I believe this is outrageous. I can understand the problem, and I can understand the parallels from the EPA, but in no case, do I accept that turning our Medicare patients into undercover secret police will benefit anyone. This is a dangerous precedent. Disgruntled patients will very soon trip to the fact that to cause grief for a physician, all they need do is report alleged fraud. It will be like an unhappy ex-spouse tripping an IRS audit. Except, in the case of the patient, there are no negative ramifications. The patient simply changes physician and leaves the mess to the government and the physician to sort out. No government agency has a good reputation for efficiency, friendliness, or helpful attitudes. I encourage you to read the rest of the press release. HCFA has unabashedly deputized 37 million members of AARP in their fight against doctors. "In addition, beneficiaries themselves are being trained to spot and report fraud and misspending."

G. Stephen DeCherney, M.D., M.P.H., is Editor of the Delaware Medical Journal and a practicing endocrinologist in Newark and Wilmington, Delaware.

Let us contemplate the new order of things. Every patient over 65, which are a large portion of any practice, will be suspect. Physicians will be the Quakers of 17th Century England or the Jews of Germany in 1939. We will never know who our next potential accuser will be or for what offense. The net will be cast over everyone practicing medicine. Although the Feds claim that the patients are being trained to spot only abuse, the training is in the form of press releases and newsletters. In fact, what the Feds are doing is training our patients to re-negotiate our fees after the fact. What the Feds have been unable to achieve through under-funded managed care programs in the Medicare market, they now hope to recoup in harassment.

Working in this atmosphere of a police state will add to the burden already imposed on us by managed care and insensitive insurance companies. These patients are the most vulnerable and most dependent on us. This policy of HCFA makes each and every one of them a potential enemy of my practice.

What is unclear to me, is how to reverse this policy. The most obvious route is to have the

legislature in Washington change it. Yet this order emanates from the Executive Branch and not directly from the Congress. For those of you not familiar with the workings of the federal government, please note that while Congress passes laws, it is up to the Executive Branch to determine how these laws are implemented. If any of you know how to influence Secretary Donna Shalala, of HHS, June Gibbs Brown, Inspector General of HCFA, or any other influential member of the Executive Branch, please speak up now. Those of you who are friendly with Senators Biden or Roth, or Representative Castle should call or write them immediately.

Finally, this is the sorry state of affairs which has changed in one generation. Medical care has become expensive due to more and better technology and the advancing age of the population. Physicians have been justifiably blamed for overuse of technologies (CAT scans for headaches) and overprescribing. These are legitimate complaints on the part of the payers. We cannot, however, be held responsible for ministering to an increasingly older and sicker population with the best tools available. This is, after all, our job.

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Confidentiality of Peer Review

Victor F. Battaglia

Very recently, a proposal was presented to the House of Delegates of the American Bar Association which would have allowed law firms to perform confidential internal audits designed to protect their clients' interests. The House rejected the proposal reasoning that allowing the result of such audits to remain confidential would be inconsistent with a lawyer's obligation under the attorney's rules of professional conduct to report lawyer misconduct, of which they become aware, to disciplinary authorities.

I disagreed with the House of Delegate's decision because the failure to allow such a practice may well inhibit the taking of corrective action to protect client interests. Why should law firms not be encouraged to do sweeping internal audits in an attempt to find and stop conduct inimical to client interests?

Victor F. Battaglia is an attorney at Biggs and Battaglia Attorneys at Law in Wilmington, Delaware.

Delaware's Medical Practices Act establishes a comparable duty to report for all health care providers. Section 1731A of Title 24 requires every licensed health care provider and health care institution to report "any information the person has reason to believe indicates a medical licensee is or may be medically incompetent, guilty of unprofessional conduct or mentally or physically unable to engage safely in the practice of medicine."

Unlike the situation presented to the ABA House of Delegates, however, the pervasive obligation of health care providers to report is trumped by a statute which provides medical peer review bodies confidentiality and immunity. (24 Del. C. §1768). That statute is designed to elevate the goal of improving the quality of medical care over the obligation to report inappropriate medical conduct such that the results of peer review proceedings may not be used for any other purpose, including criminal, civil or adminis-

trative adjudications. To be as blunt as possible, that means information gathered to improve the quality of care cannot be subpoenaed for use in a civil lawsuit and cannot be subpoenaed by the Attorney General for use in a criminal case. For example, if there is a determination by a hospital Morbidity and Mortality conference that a certain physician provided inappropriate treatment, that information would not be available for use in a medical malpractice case.

Until fairly recent amendments to the Medical Practices Act, information gathered in a Peer Review proceeding was not even available for use by the Board of Medical Practice for the purpose of disciplining a physician. Amendments to §1768 and other provisions of the Medical Practices Act (Chapter 17 of Title 24) now permit the Board to subpoena information from Physician Peer Review bodies during the course of the investigation of a physician. In addition, the Federal Health Care Quality Improvement Act of 1986 requires peer review bodies which take serious action against a physician to make a report of the results of their actions to a National Data Bank. Access to the Data Bank reports, however, is limited to licensing and credentialing bodies, such as State Medical Boards, and to health care institutions. (See 42 U.S.C. §§11133, 11137).

Section 1768 has served us well. The quality of medical care in our community is at an elevated level.

The confidentiality provisions of §1768 have been a frequent subject of court opinions. Section 1768 in part provides:

"(b) ... the records and proceedings of any such committee's or organization's ... shall be confidential ... shall not be available for court subpoena or subject to discovery ... and no person in attendance at a meeting of any such committee or organization shall be required to testify as to what transpired there at."

While the Delaware Supreme Court has not addressed §1768, there are a number of lower court decisions interpreting this provision. The

leading case is Connolly v. Labowitz, Del. Super., C.A. No. 83C-AU-1 Bifferato, J. (Dec. 17, 1984). In that case, the court announced, "... privileges are repugnant to the adversarial and judicial system in the United States and are therefore narrowly construed. The need to develop relevant facts is fundamental in all adversarial systems." In fact, the courts have determined that the need to protect the litigation process and encourage testimony is so strong that there has evolved a powerful privilege in favor of those who testify. For example, a statement made in the course of litigation which would otherwise be considered slander cannot be used for the basis for a defamation lawsuit. Barker v. Huang, Del. Super., 610 A.2d 1341 (1992).

Notwithstanding the powerful need for access to the facts incidental to litigation, the courts have given force and effect to the confidentiality provisions of §1768. In Connolly v. Labowitz the Superior Court held confidential: (1) records of the committee not published to those outside the committee; (2) the proceedings themselves which were not published; (3) testimony before the committee.

The records of the committee were held to include any paperwork, reports or compilations of data used exclusively by the committee. The court held the committee's confidentiality privilege could be waived but only by those to whom the privilege runs. That is, a witness whose testimony would otherwise be privileged could waive the privilege only as to his own testimony, not as to the committee records or the testimony of other witnesses. The court also held that the waiver of confidentiality of committee's report by its publication does not open up the committee's deliberations.

A distinction must be made between what is presented to a committee and the knowledge of those who appear before the committee. The mere fact that a paper is introduced before the committee does not confer confidentiality status to the document provided it had an origin outside the committee. Those who gave testimony before a committee cannot be required to tell what they said to the committee, but they can be

compelled in another forum to testify as to their knowledge of the underlying facts. Dworkin v. St. Francis Hospital, Del. Super., 517 A.2d 302 (1986). In other words, records or testimony do not become confidential simply because they are introduced at a peer review proceeding. For example, if a nurse testified at a peer review proceeding as to her observations of a physician's treatment of a patient, she could not be asked in a subsequent medical malpractice action what she said to the committee, but could be asked what she observed.

If a physician who was sanctioned by a peer review body brings suit attacking the action of the committee, the physician would be able to compel testimony from those who appeared at the peer review hearing, not as to what they told the committee, but only as to their knowledge of the underlying facts. In other words, the witness could not be asked, "What did you tell the committee about the surgery performed by the doctor?"; but could be asked, "Did you observe the doctor performing surgery?"

In short, hospital records, office records, and employment records are not immune from discovery or subpoena. They do not become confidential merely because they were used in a peer review process. Only records constructed solely for the peer review process are confidential and only if the privilege is not waived.

The application of the statute has not been limited to committees specifically identified in it. For example, a Task Force Committee established to investigate an accident at the Delaware State Hospital has held to be protected by the statute. Hagadorn v. Davidson, Del. Super., 1990 WL 18274 (Feb. 12, 1990).

The breadth of the statute is quite broad. In Laird v. State of Delaware, Del. Super., 1985 WL 189016 (1986), the court ruled the statute protects records compiled by the Board of Medical Practice in connection with their licensing activity. The court ruled the protection awarded by the statute extends to the Board's performance of its statutory function and is not limited to the functions enunciated in the statute.

However, letters of reference directed to a hospital during a physician's attempt to obtain staff appointments are not privileged. Riggs National v. Boyd, Del. Super., 1997 WL 528155 (1997). The broad scope of §1768 is said not to be unlimited. In Swede v. Cigna Healthcare of Delaware, Del. Super., 1989 WL 5194 (1989), the court protected minutes and agenda of Cigna's IPA Quality Assurance Program but denied protection to the proposal for the Quality Assurance Program which outlined the committee's procedures for reviewing medical care.

It should be noted that a medical malpractice review panel constituted pursuant to 18 Del. C. §6812 is not considered a peer review body protected by §1768. Neither the deliberations nor the records of such a panel are considered confidential.

The second prong of §1768 is also quite important. It provides immunity from suit from those who participate in the peer review process. For example, a physician who is disciplined by a peer review body would not be able to bring an action for damages against members of the committee.

This immunity applies to any common law claim or one based upon a Delaware Statute. However, because of the supremacy clause of the United States Constitution (Article 6) §1768 would not protect members of a peer review body from suits based upon federal laws or the United States Constitution. For example, §1768 would not provide immunity from an anti-trust suit. Happily, the federal government has provided a corresponding immunity in the Health Care Quality Improvement Act. That law, enacted in 1986, was based in part on a finding that "there is an overriding national need to provide incentive and protection for physicians engaging in effective peer review." (42 U.S.C. §11101(5)).

If a peer review body follows certain due process type procedures set forth in the Health Care Quality Improvement Act, the members of the peer review body would be immune from suit, including suit for damages under the anti-trust laws.

CONCLUSION

The provisions of §1768 appear to have served us well. We are not alone. Most jurisdictions have adopted similar provisions. These appear not to have impeded litigation. The amendments to the statute which have allowed the Board of Medical Practice access to peer review records, however, will most likely have some chilling effect on peer review actions. I believe these amendments should be reconsidered.

Vigorous peer review can and should be the most important vehicle for continuing to elevate the quality of care of patients. If regulatory bodies like the Board of Medical Practice are allowed to have access to peer review proceedings, those who participate are not as likely to be as critical as they might otherwise be. Disallowing the Board access to the peer review process would

not limit the Board's right to investigate care alleged to be problematic. The small advantage gained from reviewing peer review records is very much offset by the chilling effect on the peer review process.

Another shortcoming is that §1768 does not prohibit those who testify before it from discussing their testimony. It only bars those who have testified from being required to disclose their testimony. In effect, it allows participants to pick and choose what shall become public and what is protected. The statute would be improved by including a prohibition on those who attend peer review proceedings from providing any information about the proceeding, making it clear that it is their testimony which is protected, not the information possessed by the witness.

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A Health Information Network For Delaware

Michael Zaragoza, M.D.

Imagine, if you will, as a primary care physician, that you've just seen an office patient who needs a semi-urgent referral to a specialist. With the click of a mouse, an authorized referral to a participating specialist is made and with a second click, a claim for your own office visit is submitted electronically to the patient's insurance company. Now imagine, as a specialist, you see the same patient in your office the following day with a referral confirmed electronically. Surgical intervention is recommended and before the patient completes the paperwork, pre-authorization for the procedure is obtained over the computer. At the same time, an electronic claim for the office visit is generated with an extra stroke of the keyboard. Within two days, remittance to both PCP and specialist is received electronically and funds are transferred to the respective local accounts.

Does this sound too good to be true? Maybe, yet there is a growing effort to address the labor-intensive business side of medicine and transform the above scenario into reality.

In 1998, Governor Carper signed legislation creating the Delaware Health Information Network (DHIN) as a branch of the Delaware Health Care Commission. The mission of the DHIN is to facilitate the transfer of health care data on a statewide level. Undoubtedly a formidable task, the endeavor hopes to succeed with the

cooperative efforts of all parties involved - physicians, hospitals, insurers, employers, consumers, state government, and policy makers. Accordingly, each entity has representation on the DHIN board.

Since its inception 1 year ago, the DHIN has worked diligently to identify several important issues in pursuit of its stated goal. At this point, the three major overriding concerns are: 1) prioritization of electronic interactions based on the level of value to each of the constituents in the network, 2) assessment of the level of technical readiness available to support such a network and 3) most importantly, assuring privacy and confidentiality.

Many states have attempted this type of network and many have failed. One success story lies in the state of Utah, where greater than 90 percent of physicians participate in the Utah Health Information Network. With a state the size of Delaware, we have an ideal setting to implement a statewide network for data interchange that will ultimately improve the quality and efficiency of health care delivery for Delawareans.

Electronic claims, for example, save time and money, estimated at \$1.25 per claim by one Delaware insurance company. By eliminating paper claims, physicians can improve efficiency and lower costs as well. Moreover, we all recognize the inordinate amount of time spent by staff on the phone, usually on hold, trying to obtain referrals or authorizations. Imagine the en-

Michael Zaragoza, M.D., is Associate Editor of the Delaware Medical Journal and serves as a member of the Delaware Health Information Network Board.

hanced productivity if computerized transactions were used instead. Through equal opportunity technology, the DHIN provides a means to reduce, and hopefully, eliminate the nonmedical "hassle factors" which have become increasingly burdensome in our practice.

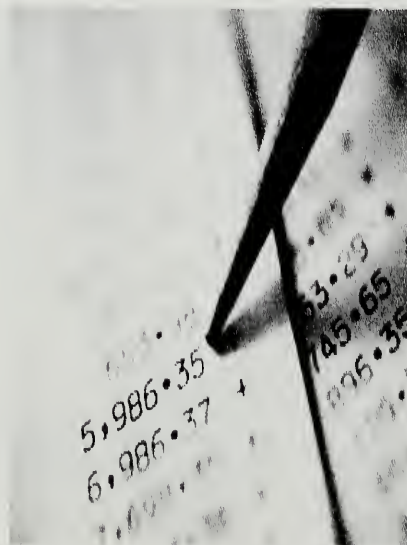
Like all well-intentioned ideas, no matter how promising, the DHIN endeavor requires careful consideration and well-balanced input to create and sustain a meaningful existence. At present, the major roadblock to electronic data interchange is the implementation of a single standard electronic form which is compatible with all providers and insurers at a minimal cost to each. Be assured that some of the major players such as hospitals and insurers have devoted significant time and effort to make certain their views are represented at the table. Now is the

time for us as physicians to contribute thoughtful input and ensure equal representation on the matter.

Each licensed physician in the state will be receiving a survey from the DHIN regarding statewide electronic data interchange and technical readiness. I urge you to respond so that your concerns will be heard at the ground level. As medicine becomes more and more fused with corporate America, the less likely we are as individuals to have an impact on the practice of medicine. Changes are no doubt going to occur, with or without our input. Here's our chance to pull in the reins on the avalanche of paperwork and redirect our energy to issues of medicine. It's time for us to act locally and get involved in our future. So, please act.

Editor's Note:

The Medical Society will be publishing more information on this topic as it becomes available. Meanwhile, interested readers may want to visit: <http://www.healtheon.com>. Healtheon intends to integrate many of the functions mentioned in Dr. Zaragoza's editorial.



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Reports from the December 1998 AMA Interim Meeting

REPORT OF THE REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

Submitted by Michael J. Bradley, D.O.

Specialty Organization Representation in the House of Delegates

The following organizations retained their seats in the HOD; American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Pain Medicine, American Academy of Physical Medicine and Rehabilitation, American Academy of Pediatrics, and the American Association of Neurological Surgeons. The American Academy of Allergy, Asthma and Immunology was given a year to correct its membership deficiency.

CEJA (Council on Ethical and Judicial Affairs) Report 3: Conflicts of Interest - Biomedical Research

In addition to established requirements on full disclosure, CEJA recommends that an explanatory statement disclosing conflicts of interest to readers should accompany published research and any other types of publications, such as letters to the editor.

CEJA Report 5: Ethical Considerations of Fees for Referrals

Paying a fee to receive referrals is unethical and covered by Opinion 6.02, which is reaffirmed.

Resolution 8: AMA-MSS Membership Qualifications

Active AMA-MSS membership is contingent upon enrollment in a LCME accredited allopathic or AOA accredited

osteopathic medical school in the U.S. or its protectorates.

Council on Constitution and Bylaws (C&B) Report 1: Definition of Resident

Amends the bylaws to expand the Resident Physicians Section to include physicians who are participating in a structured post medical training program and those on military or Public Health Service active duty prior to completion of a residency. Also calls on renaming the RPS to the Resident and Fellows Section.

C&B Report 3: Representational Role of AMA Delegates

Specifies the multi-dimensional role of Delegates to include: advocacy for patients to improve public health and the health care system; representation of the perspectives of the

delegate's sponsoring organization to the House of Delegates; representation of the Delegate's physician constituents in the House's decision process; and representation of the AMA and the House of Delegates to physicians, medical associations and others.

CEJA Report 2: Physicians' Political Communications with Patients and Their Families

It is laudable for physicians to exercise the full scope of their political rights, individually or through organization. Physicians have a responsibility to be well-informed on needed quality care. Communications with patients and families about political matters must be conducted with utmost sensitivity to patients' vulnerability and privacy. Conversations about political matters are not appropriate when patients or families are pressured by immediate medical problems. When conversation with the patient or the patient's family on social, civic, or recreational matters is appropriate, discussion of items of political import may be appropriate. Physicians should not allow differences with patients or their families on political matters interfere with the delivery of professional care of high quality.

CEJA Report 4: Direct-to-Consumer Advertisements of Prescription Drugs

Addresses the strengths and pitfalls of direct advertising to consumers and recommends: Physicians should work to ensure an FDA commitment to standards that protect patients' health, safety, and resources; Physicians should encourage studies on the effect of advertising on patient health and medical care; Physicians should resist pressure to prescribe non-indicated drugs; Physicians should remain vigilant to assure that advertising does not promote false expectations.

Resolution 1: AMA-MSS Speaker and Vice Speaker Reform

Makes the Speaker and Vice Speaker of the AMA-MSS ex-officio, non-voting members of the AMA-MSS Governing Council.

Resolution 2: Professional Courtesy
Resolution 6: Preservation of Professional Courtesy

Calls for the AMA to petition HCFA, the U.S. Attorney General and the US Congress to reverse the unreasonable and intrusive policy of considering professional courtesy among physicians as fraud.

Resolution 4: Confidential Patient Information to Fourth Parties

Resolution 9: Legality of Federal Agents

Directs that our AMA investigate, and challenge where appropriate, the authority of federal agents (including armed law enforcement agents) to obtain confidential patient information in the absence of appropriate search warrants.

Resolution 5: Physician-Assisted Suicide

Recommends that our AMA strongly oppose any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.

Resolution 7: In-office Marketing of Vitamins and Supplements

Directs that the AMA develop ethical guidelines that will discriminate between the legitimate provision of medically necessary goods and services in physicians' offices and physicians' marketing activities that exploit the patient-physician trust.

Report 2: Opinions and Reports from CEJA C&B

Clarifies the way the HOD responds to Reports and Opinions from CEJA.

CEJA Opinions will be considered informational and filed. Motions are in order to extract an Opinion and request that CEJA reconsider or withdraw an Opinion. CEJA Reports may be adopted, not adopted or referred, and may be amended for clarification only with CEJA's concurrence.

CEJA Report 1: Impaired Drivers and Their Physicians

Focuses on the ethical obligations of physicians when faced with patients whose driving ability is impaired by physical and/or mental conditions. This report was referred back to the Council for reconsideration and rewrite, due to extensive testimony on the report's shortcomings.

Resolution 3: Patient Confidentiality

Relates to the escape of confidential information outside of the patient-physician relationship. This was referred to the Board of Trustees, since a Task Force has been charged with developing a detailed report on this subject.

CEJA Opinion 6: Ethical Conduct in Assisted Reproductive Technology

Recommendation for reconsideration was approved. This Opinion was based on reports from CEJA/CSAA-96 relating to areas of potential deception and exploitation of patients. Numerous speakers mentioned the improvements made in the last two years, and the consensus was to ask CEJA to involve the specialty societies and reconsider their opinion.

CEJA Opinion 9: Collective Action and Patient Advocacy

Reports on the ability of physicians to have a collective action as long as it is conducted in a manner that does not jeopardize the health and interests of patients.

CEJA Opinion 11: Reporting Clinical Test Results - General Guidelines
Recommendation for reconsideration was adopted. There were many problematic areas of how to report test results to patients. These included messages left on answering machines, faxes, e-mail and others. The opinion was too restrictive such that even with prior patient approval a simple message could not be left.

CEJA Opinion 12: Information from Unethical Experiments
States that if data from unethical experiments can be replaced by existing ethically sound data and achieve the same ends, then such must be done. In the extremely rare case when no other data exist, and human lives would certainly be lost without the knowledge obtained from use of such data, publication or citation is permissible.

C&B Report 4: Guidelines for Medical Society Bylaws
Presents guidelines for local medical society bylaws.

CEJA Opinion 8 - Court Initiated Medical Treatments in Criminal Cases
Safeguards the participation of physicians in court-initiated medical treatments in criminal cases, limited only to those that are medically appropriate.

REFERENCE COMMITTEE A

BOT Report 38: Negotiated Rulemaking
Adopted BOT Report 38, calling on the BOT to provide an update to the House at the 1999 Annual Meeting regarding the negotiated rulemaking for lab tests and other regulatory and legislative developments in the administration of Medicare's lab test benefit. The committee also reaffirmed the need for the AMA to continue its participation in the negotiated rulemaking process.

Resolution 122: Y2K Readiness, Resolution 109: Universal Insurance
Adopted Resolution 122, which continues efforts to ensure Y2K readiness, and Resolution 109, which calls upon the AMA to continue its efforts to provide affordable health expense coverage for all segments of the uninsured.

REFERENCE COMMITTEE B Submitted by Michael S. Katz, M.D.

Actions taken by The AMA House of Delegates on Reference Committee B resolutions (Legislation) included Medicare Private Contracting, Expert Witness Testimony, Medical Director Liability, Fraud in the Medicare Program, and Retroactive Denials Under Federal Health Plans.

Interpreters for Physician Visits
Asks the AMA to seek enactment of legislation to clarify the provisions in the Americans with Disabilities Act requirement relating to the provision of qualified interpreters for hearing impaired patients.

Anti-kickback Implications of Ambulance Restocking
Asks the AMA to support federal legislation to create a safe harbor under the anti-kickback statute of ambulance restocking by hospitals.

Medicare Private Contracting
Asks the AMA to support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries' freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective.

Utilization Review Accountability in Torts
Directs the AMA to draft and disseminate model state legislation for utilization review accountability by A-99

Board of Trustees Report 14: Status of the Learned Professions Under Antitrust Law
Directs the AMA to continue its efforts to support the Campbell Bill and to secure relief for physicians from overbroad application of the antitrust laws. This report also seeks to continue pursuing input from physicians in all areas of practice regarding the nature of antitrust relief needed to assure that the delivery of quality of medical care is not infringed upon; that the AMA continue to identify ways in which collaboration by physicians can benefit the public; to inform antitrust enforcement agencies of these findings.

Board of Trustees Report 16: Congressional Health Bill 1062
Asks the AMA Government Affairs staff to continue to work with the sponsors of HR 4431, the HIV Partner Protection Act of 1998, and any successive legislative vehicles to ensure that AMA policy is advocated.

Board of Trustees report 18: Expert Witness Testimony
Directs the AMA to encourage each state medical society to work with its state licensing board to grant any out-of-state expert witness physician a temporary license at a nominal fee or at no cost for the express purpose of expert testimony on a per case basis, such that the expert witness is subject to the peer review process. Also to work with the Federation of state medical boards to address problems regarding out-of-state expert witnesses. The AMA is directed to act as a clearinghouse for advice and support as the state medical associations develop their own expert witness committee programs.

Board of Trustees Report 34: Medicare Fraud and Abuse Update
Directs the AMA to seek congressional intervention to halt abusive practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors.

Board of Trustees Report 36: Private Sector Advocacy Activities Update

Directs the AMA to continue to aggressively advocate in the private and public sector to level the playing field between physicians and health care payers including the development of a negotiating unit, free of antitrust constraints, within organized medicine and with no national trade unions affiliation, as advocate by resolution 258, A-98.

Medical Director Liability

Asks the AMA to develop policy that medical directors of insurance companies be held accountable and liable for medical decisions for contractually covered medical service and that the AMA undertake federal legislative and regulatory measures to implement this policy as a high priority.

Fraud in the Medicare Program

Directs the AMA to continue efforts to educate the entire Federation about the AMA's successful amendment to the AMA Health Insurance Portability and Accountability Act which resulted in language being added so that physicians cannot be prosecuted or fined for inadvertent billing errors, absent of any intent to knowingly and willfully defraud.

Prevention of Unintentional Shooting Deaths Among Children

Asks the AMA to support legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner and that the specifics be determined by the individual constituencies affected by the law.

Retroactive Denials Under Federal Health Plans

Directs the AMA to support legislation in Congress to establish time limits on retroactive denials of claims under ERISA and FEHB laws and to draft model state legislation estab-

lishing time limits on retroactive denial of claims.

Antitrust Exemption for Insurance Companies

Directs the AMA to pursue all necessary means, including legislation and community education, to modify, reduce, or eliminate the antitrust exemption afforded the insurance industry.

Opposition to Criminalizing Health Care Decisions

Asks the AMA to educate physicians regarding the continuing threat posed by the criminalization of health care decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Health Care Decision-making".

Support Hate Crimes Prevention Legislation

Directs the AMA to urge expedient passage of appropriate hate crimes prevention legislation in accordance with AMA policy H-65.992 through letters to members of congress.

Anesthesiology is the Practice of Medicine

Directs the AMA to seek legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy or dentistry.

REFERENCE COMMITTEE C

Submitted by Alfonso P. Ciarlo, M.D.

The following is a brief summary of the activities of Reference Committee C, Medical Education. The following reports and/or resolutions were recommended for adoption.

Board of Trustees Report 30: The Patient/Physician Relationship and Medical Licensing Boards

Recommends that the AMA encourage state medical societies to advocate for the inclusion of a statement

concerning patient-physician relations in state medical licensing board regulations and transmit this policy to state medical societies.

Report 4 of the Council on Medical Education: Extending Impaired Physician Programs to Medical Students

Recommends that the AMA policies on inclusion of medical students and resident physicians in medical society impaired physician programs be reaffirmed and that medical schools work to inform students of available treatment and other medical school programs.

Report 8 of the Council of Medical Education: ACCME "System 98" A New System for CME Accreditation

Describes a new system for accreditation of continuing medical education that was adopted by the ACCME. It was pointed out that the new system of ACCME accreditation provides needed flexibility in continuing medical education accreditation while maintaining the key concepts of the prior Essentials and Standards.

Report 9 of the Council of Medical Education: Conscience Clause - Final Report

This report contains the final set of principles that medical schools could use in permitting students to be excluded from scheduled activities to which they have religious or moral objections.

Report 10 of the Council of Medical Education: Training in the Treatment of Addiction

This report reaffirmed existing policies of the AMA with regard to training and education in drug abuse, alcoholism and substance abuse prevention and reviewed existing requirements for such education and residency programs.

Report 10 of the Council of Medical Service: Ratio of Physician to Physician Extenders

Asks our AMA to study the appropriate ratio of physicians to physician extenders in which the physician can

effectively direct and supervise the treatment and care of patients.

Training in Reimbursement Coding During Pregnancy

Asks our AMA to encourage residency program directors to incorporate training in practice management, including training on proper reimbursement coding and documentation into residency programs.

Teaching Professionalism Across the Continuum

Asks the AMA to support the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education and that the AMA work to develop plans to address teaching and learning of professionalism as part of medical education.

Report 1 of the Council of Medical Education: Progress in Medical Education Structuring the Fourth Year of Medical School

This report proposes that the fourth year of medical school remain flexible and form a continuum with the third (clinical) year. Medical students should be given advice on choosing their elected program and their eventual specialty.

Health and Disability Insurance Coverage for Medical Students and Resident Physicians

Asks the AMA to actively encourage medical schools, residency programs and fellowship programs to provide portable group health and disability insurance, including HIV positive indemnity insurance for all medical students, residents and fellow physicians.

Support for the Accreditation of the United States Medical Schools

Ask that the AMA encourage efforts to educate all prospective medical students about the potential implications of attending any non-liaison committee on medical education/

American Osteopathic Association accredited medical education programs.

Board Certification and Discrimination

Asks the AMA to reaffirm and communicate its policy of opposition to discrimination against member physicians based solely on lack of board certification and that the AMA collect information from members discriminated against solely because of lack of board certification.

Many other resolutions and reports on medical education were considered and referred or filed.

REFERENCE COMMITTEE D

Submitted by James P. Marvel, M.D.

A brief summary of the actions and activities of Reference Committee D at the AMA House of Delegates Meeting in Hawaii in December 1998, relating to Public Health and Safety are as follows. The following items were adopted:

Council on Scientific Affairs Report 5: Air Travel Safety

This report contained numerous recommendations for improving aviation safety and security and air traffic management. Although it was felt to be outside the purview of most physicians, the federal document raised awareness of the need for national action to ensure greater public safety and security in airports and aboard aircraft. There was limited, but supportive, testimony heard in favor of the report and recommendations.

Resolution 425: Gun Safety

This asks the AMA to recommend and promote the use of trigger locks and gun cabinets and to endorse standards for firearm construction reducing the likelihood of accidental discharge when a firearm is dropped. Testimony on Resolution 425 was uniformly favorable and it was further noted that the position advocated in

the resolution has essentially become the industry standard and that firearm injuries have declined in recent years due in part to such measures. Testimony also noted the support of many medical specialty societies and public health groups.

Resolution 403: Research on Violence in School Settings

This resolution would provide for reports on incidence of school violence, effects of media reports on such violence and value of school-based curricula on violence.

Resolution 411: Achieving National Adolescent Immunization Goals by the Year 2002

This resolution sought AMA endorsement of the National Adolescent Vaccine Coverage Goals for the years 2000 and 2002 as well as a collaborative effort by physicians and state officials to meet the goals. Surprisingly, absolutely no negative testimony was heard on this resolution.

Council on Scientific Affairs Report 10: Bloodborne Pathogen Transmission To and From Health Care Workers

The recommendations in this report were adopted.

It was noted that this report was based on scientific data from the six years since 1991 and would amend existing policy as well as establish new policy. First, HIV-infected health care workers should not have practice restrictions imposed on them unless there is a "significant risk" of patient infection; the use of the term "significant risk" is recommended for all AMA policy concerning bloodborne pathogens that can be transmitted to patients because the term is well defined and has precedence in medical practice, policy, science and law. Second, most recent scientific evidence would dictate separate guidelines for HIV- and HBV-infected health care workers. This is currently not the case with the CDC guidelines, which base HIV guidelines for in-

fect health care workers on data obtained from HBV-infected health care workers. Thus, the report recommends such separation of the guidelines and further recommends that the CDC revise the guidelines accordingly.

Significant praise was heard for this report from the Council on Scientific Affairs and speakers urged its widespread and rapid dissemination.

Resolution 413: Energy Efficiency and Medical Practice

This resolution would have the AMA encourage energy efficiency in the medical work place. Testimony on this resolution was limited, but supportive.

Resolution 428: International Tobacco Control Efforts

This resolution requested that the AMA support tobacco control efforts of the World Health Organization and urged governmental agencies to participate in international tobacco control efforts.

Resolution 418: Public and Private Funding of Prevention Research

This resolution asks that our AMA work with the public health community to develop a prevention research agenda and work with relevant groups to develop a plan to implement recommendations.

The following reports were recommended for adoption as amended or substituted.

Council on Scientific Affairs Report 6: Options for Improving Motorcycle Safety was Adopted in lieu of Resolution 406

A comprehensive national motorcycle safety plan that addresses rider education, training, and licensing; use of motorcycle helmets and other protective gear; public awareness of motorcycles; Alcohol use among

motorcyclists and other motor vehicle drivers; measures to increase the visibility of motorcyclists and motorcycles to other drivers; engineering and design of motorcycles and highway environments; and research to determine the effectiveness of current proposed safety measures.

The Reference Committee heard uniform support for the report and recommendations. There was, however, discussion on the need for additional recommendations to improve the visibility of motorcyclists and motorcyclists to other drivers and on the important effect of alcohol in motorcycle related crashes.

Resolution 410: Resources for Victims of Domestic Abuse in the Adolescent Population

This resolution asks that the AMA develop a program to place informational signs about domestic violence, including local resources, in the restrooms of junior highs and high schools around the country.

The substitute resolution proposed that the AMA develop materials on domestic violence, partner abuse, and date violence that are suitable for use in junior high and high schools and work with the alliance and state medical societies in an effort to ensure the distribution and placement of these materials in junior high and high schools around the country.

Resolution 424: Workplace Violence and Abuse Prevention

This resolution was amended to ask that the AMA encourage all health care facilities to adopt policies to reduce and prevent workplace violence and abuse and to develop policies to manage reported occurrences of workplace violence and abuse.

Resolution 424 relating to the same matter was likewise amended to ask that the AMA encourage hospitals and clinics to have policies on workplace violence and abuse.

Resolution 404: Use of Protective Eyewear by Athletes

This resolution was adopted as amended resolving that the American Medical Association policy support the use of protective eyewear for sports participants who have had intraocular surgery or eye trauma or are functionally one-eyed individuals, and for all other sports participants engaged in high risk eye injury sports, as advocated by the American Academy of Pediatrics and the American Academy of Ophthalmology.

There was uniform testimony in favor of this resolution and it was noted that comments indicated that more than 40,000 sports related eye injuries are treated each year in the United States, affecting all sports to some degree.

Resolution 405: Prevention of Injuries to Children From Recreation Trampoline Use

A substitute resolution was adopted resolving that the American Medical Association work with appropriate federal agencies, national safety organizations and medical specialty societies to develop appropriate information that physicians can provide to parents on the risks of injury to children and guidelines for safe, home trampoline use.

Resolution 429: School Bus Safety

This resolution was submitted as a resolution from the young physicians section of the Medical Society of Delaware. This was adopted in an amended form resolving that the AMA petition appropriate federal agencies to conduct a study to evaluate school bus structure and safety

and the need for child restraint systems on all current school buses and propose national standards for use in national legislation.

Resolution 427: Chemical Analysis Report of Public and Commercial Water

This resolution was adopted as amended resolving that the AMA request the appropriate federal agency to require analysis and appropriate labeling of the chemical content of commercially bottled water as well as the water supplies of cities and towns.

An additional resolve was adopted asking that the AMA work with the American Dental Association to promote the availability of fluorinated commercially bottled water to consumers.

Resolution 416: Hotels Used by the AMA

This resolution sought to avoid holding AMA meetings in hotels that cater to tobacco interest or are owned by tobacco companies and asked for a report on the implementation of Policy H-530.993.

Substitute Resolution 431 was adopted in lieu of Resolutions 431, 432, 433, 434, 436 and 437. This resolved that the AMA undertake action to publicize support and implement the elements of its policy that have not been adequately addressed by the Master Settlement Agreement and other agreements, including but not limited to:

- A complete ban on tobacco industry promotion and advertising
- Regulation of tobacco sales, including a ban on vending machines and a mandate for behind the counter sales
- Tax increases on tobacco products
- Protection from environmental tobacco smoke
- Regulation of nicotine as a drug by the Food and Drug Administration

It was further resolved that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized first to increase the budget for tobacco cessation and prevention programs including research, education, prevention and treatment of nicotine addiction, especially in children and adolescents and treatment of diseases related to nicotine addiction and tobacco use. It was further resolved that the AMA strongly support efforts to direct tobacco settlement monies not directed to other specific tobacco control activities, to increase patient access to medical services and that the AMA support legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state's Federal Medicaid match. In addition, it was resolved that the support efforts to assure any tobacco settlement funds not supplant but augment health program funding.

Resolution 419: Potential Accreditation Process for Public Health Departments

This was adopted as amended resolving that the AMA work with relevant agencies and organizations to develop a process to establish criteria for the voluntary accreditation of state and local health departments.

Resolution 423: Health Care for Young Adults

This was adopted as amended, asking that the AMA research the need for a national initiative on health care needs of young adults and, if needed, AMA development of a public information campaign to inform young adults on common health risks.

Resolution 401: Air Travel Restrictions on Patients Requiring Supplemental Oxygen in Flight

It was recommended that this resolution be referred. This resolution asks the AMA to petition the Department of Transportation and the Federal Aviation Administration to revise regulations on the transport of medical oxygen. It supports requiring airlines to supply passengers needing oxygen with same during stays in airports and asks AMA members to write regulators and Congress to support this change. It was recommended that the Council on Medical Services study this issue further.

ment of Transportation and the Federal Aviation Administration to revise regulations on the transport of medical oxygen. It supports requiring airlines to supply passengers needing oxygen with same during stays in airports and asks AMA members to write regulators and Congress to support this change. It was recommended that the Council on Medical Services study this issue further.

Resolution 426: Telemedicine EKGs for Airlines

It was recommended and adopted that this recommendation be referred, seeking to have our AMA recommend the development of a program to facilitate EKG transmissions from airplanes and interpretation of these EKGs by qualified ground personnel. There was significant conflicting testimony regarding the benefits of transmitting EKG information to medical personnel on the ground. It was felt that even if such information were made available to ground personnel for evaluation, concern was expressed that commercial aircraft may lack appropriate medical supplies to treat in-flight cardiac emergencies. It was further noted that the Council on Scientific Affairs had indicated that they are working on a report on the use of automatic external defibrillators aboard commercial aircraft and recommended that the issue raised in this resolution be considered in that report.

Resolution 409: Pre-participation Screening in Student Athletes

It was recommended that this resolution be referred, which would support inclusion of the American Heart Association's 13-question pre-participation cardiovascular questionnaire in athletic physicals, with appropriate follow-up for athletes identified to be at risk. Reference Committee recommended and it was accepted that this be referred to update physicians on recent expert guidelines for pre-participation physical examinations and to review recommendations of the American Heart Association.

Resolution 435: Detection, Diagnosis and Intervention of Hearing Loss in Newborns and Infants

It was recommended and accepted that this resolution be referred supporting statewide programs for the early detection and diagnosis of hearing loss in newborns and infants. It was noted that at least twelve states are currently screening for hearing loss in infants with good results. The prime reason for referral, however, was the fact that concerns were raised about a false/positive rate of as much as 30 percent utilizing current screening modalities, and members of the public health community advocated for a careful review of the science before adoption of this resolution. It is further noted that the American Academy of Pediatrics has a report on this issue forthcoming that should answer some of the questions raised in this resolution and that this would help guide AMA policy as well.

Resolution 421: Eliminating Tuberculosis in the United States

It was recommended that this report be referred, asking the AMA to work with the CDC and other agencies to encourage screening for tuberculosis in foreign visitors entering the United States for more than 120 days with screening for all children who are born and reside outside the United States and are brought to the United States to reside.

Resolution 407: Mandatory Coverage of Medical Students for Accidental Exposure

It was recommended that this resolution be referred and such was adopted. This asks for the AMA to study the applicability to students of OSHA standards regarding bloodborne pathogen exposure.

Resolution 430: Privacy and Confidentiality

The House of Delegates referred this resolution to the board who signaled its willingness to study the issue by means of the joint Board-Council Task Force on privacy and confidentiality.

Resolution 415: Chlamydia Trachomatis

Substitute Resolution 415 was adopted resolving that the AMA support the application of strategies used to control sexually transmitted diseases for the prevention and control of *chlamydia trachomatis*. It was further resolved that the AMA encourage physicians to participate in strategies for prevention and control of *chlamydia trachomatis*.

Resolution 402: Guns in School Settings

This resolution was adopted as amended resolving that the AMA recommend that all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or other appropriately trained mental health professional.

Resolution 417: Alcohol, Nicotine and Other Drug Use and Addiction in the Medical Record

This resolution asks the AMA to encourage use or abuse in relevant clinical portions of the patient's record rather than in social history sections of the record. It is noted that the House of Delegates did not adopt this resolution.

REFERENCE COMMITTEE E
Submitted by Richard Simons, D.O.

The following is a brief summary of the activities of Reference Committee E, Science and Technology.

I. The following reports and/or resolutions were recommended for adoption.

Council on Scientific Affairs Report 7: Recommendations for Colorectal Cancer Screening and Surveillance in People at Average and at Increased Risk

This excellent CSA report reviews the evidence both for and against the screening of sporadic colorectal cancer (CRC) in people at average or normal risk, as well as in those at high risk, (i.e. with familial genetic

syndromes). It describes various screening procedures for detection of CRC and recommends a set of guidelines for the screening of various populations.

Resolution 502: Increasing Bone Marrow Screening

Asks our AMA to support efforts to increase blood donor awareness of bone marrow screening through the addition of a question on a questionnaire required for blood donation that will assess the donor's interest in obtaining information about bone marrow donation. Such information will be provided to those donors who indicate an interest. This resolution was supported by multiple appropriate organizations including the National Marrow Donor Program, American Cancer Registry, and the Leukemia Society of America.

Resolution 512: Private Breast-feeding Facilities in Public Facilities

Asks our AMA staff to work with facilities where AMA meetings are held to designate an area for breast feeding and breast pumping and to encourage public facilities to provide designated areas for breast feeding and breast pumping.

Resolution 518: Standard Format for Date and Drug Identifiers in Medical Transactions and Medical Records Keeping

Asks our AMA to vigorously participate in the development of standards regarding the development of electronic medical record standards, paying particular attention to the appropriate data elements for designing the dates and identity of drugs prescribed to patients. These standardized formats are considered important in light of increased national and international data sharing and may reduce errors inherent in entering and re-entering data.

II. The following reports and/or reso-

lutions were recommended for adoption as amended or substituted.

Council on Scientific Affairs Report 1: Priorities in Clinical Preventative Services

This CSA report was developed in response to Resolution 509 (I-97) regarding the AMA role in prioritization of preventative services and patient education. During the past year, a nonprofit coalition of health groups, the "Partnership for Prevention" formed a committee on clinical preventive service priorities to study the relative importance of clinical preventive services. Committee members represent clinicians, state and local public health agencies, health plans, purchasers of health care, consumer advocacy groups, and universities. The CSA recognized the considerable effort, expertise, and resources that have been expended on this project and found no reason to duplicate it. The recommendations, therefore, included 1) that the AMA commend the partnership for prevention for its activities in studying clinical preventative services' priorities and review the report of the committee on clinical preventive services' priorities as soon as it is available, and 2) that the AMA explore participating and further refinement and future versions of the committee on Clinical Preventative Services' Priority Report, and 3) that when the final report of the Partnership for Prevention becomes available, the Council on Scientific Affairs evaluates and prepares a concise summary of the report for wide dissemination.

Council on Scientific Affairs Report 2: Physician Education of their Patients about Prescription Medicines

This CSA report responded to referred Resolution 501 (I-97) and addressed the topic of physician education of their patients about prescription medicines. The report 1) provides an overview of medication and compliance; 2) reviews Food

and Drug Administration and AMA surveys of consumers on receipt of oral and written prescription medicine information from physicians; 3) describes past AMA efforts and current AMA policies regarding patient medication information; 4) discusses the development and AMA Board of Trustees approval of *Guidelines for Physicians for Counseling Patients about Prescription Medications in the Ambulatory Setting*; 5) evaluates the role of patient medication cards and routine medication reviews; and 6) offers recommendations for physicians and the AMA. The report is a fairly extensive review of this topic. The recommendations (amended) were as follows: 1) that Policy H-165-896 be modified to read as follows; "that the AMA encourages physicians to counsel their patients about their prescription medicines and when appropriate to supplement with written information"; and supports the physician's role as the "learned intermediary about prescription drugs"; and that Policy H-115.991, regarding the discontinued patient medication instruction (PMI) program, be rescinded; 2) that the AMA support and widely disseminate the *Guidelines for Physicians for Counseling Patients about Prescription Medications in the Ambulatory Setting*; 3) that the AMA encourage physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office based practice, which may also include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information; and 4) that the AMA continue to participate on the National Council on Patient Information and Education (NCPIE) to foster better medication use through improved communication through physicians and their patients, and that the AMA encour-

ages state and specialty medical societies to become members of NCPIE.

Council on Scientific Affairs Report 3: Economic Impact of PASARR on Hospitals

This CSA report responds to referred Resolution 802 (I-97), which asks that the AMA carefully scrutinize the whole pre-admission screening and annual resident review (PASARR) program at the national level to assess the actual impact of the program and cost effectiveness of the PASARR process as it applies to hospital discharge nursing home admissions. The CSA examined the available data on PASARR. While evidence suggests that some regulatory elements stemming from OBRA-87 have proven beneficial, particularly those regulations dealing with the use of psychoactive medications and physical restraints, there is a serious and unfortunate lack of data on the pre-admission screening and annual resident review program. Under these circumstances, the CSA was unable to assess the program as called for in the referred resolution. More importantly, the council believes adequate data is not likely to become available in the absence of a review by HCFA or other appropriate federal agencies. The CSA recommendations, therefore, included 1) that the AMA work with HCFA to commission a study to examine: a) the efficacy of the PASARR program in meeting the original intent of identifying patients with active psychiatric disorders requiring treatment; b) the extent of variation among states in applying the PASARR program; c) the cost and benefits of PASARR screening; d) procedures to improve the sensitivity of the screening process; e) the identification of more appropriate care settings for patients who are considered by the process not to be appropriate for nursing home care (i.e. how many patients are screened out); and f) the extent to which rec-

ommended interventions and treatments are actually implemented. Recommendation 2 – that the AMA reaffirm Policy H-280.969, which advocates working with HCFA to simplify nursing home regulations and reduce related administrative burdens. The title of the report was therefore changed to “Economic Impact of PASARR on hospitals, physicians, and patients.”

Council on Scientific Affairs Report 4: Safety of Blood and Blood Products Imported from Foreign Countries

This CSA report addresses the safety of blood and blood products imported from foreign countries via an examination of the current scientific literature, media, and governmental regulations on legislation. Current FDA standards for biological products and good manufacturing practices for drugs and devices apply to the production of blood and blood products in the United States. Blood and blood products that are imported into the United States are subject to the same standards and good manufacturing practices as blood and blood products derived in this country. This is a requirement of the licensure process that provides licenses to any facility or product that will be engaged in interstate or international movement of products. Foreign blood facilities must provide an unsuspended and unrevoked license; otherwise their products will be denied entry. Consequently, foreign blood and blood products should be as safe as domestic blood and blood products. The following recommendations were adopted: 1) that the AMA support current federal regulations and legislation governing the safety of imported blood and blood products; 2) that the AMA encourage the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United

States; and 3) that our AMA request periodic reports from the FDA on the safety of imported blood and blood products.

Council on Scientific Affairs Report 8: Preservation of Medical Records

This report reviews current regulatory and legal standards regarding retention of medical records, notes, current related CEJA opinion and AMA activities, and offers recommendations for establishing the policy. The following recommendations were adopted (as amended): 1) that the following statement be adopted as policy; “Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes, chemotherapy records, and records documenting permanent structural alteration to the patient should always be part of the patient's chart.”; 2) that our AMA work with other appropriate organizations to further study and develop principles and criteria for the retention of medical records; 3) that our AMA monitor progress and information technology leading to a development of a practical and secure personal electronic medical record.

Council on Scientific Report 9: Truth in Nutrition Labeling

This CSA report title was changed to “Truth in Nutrition Labeling Related to *Trans* Fatty Acids.” The resolution was introduced because the FDA has no requirement for separately listing amounts of *Trans* fatty acids in foods and no guidelines for allowed amounts of *trans* fatty acids in foods labeled as “low fat” or “low cholesterol.” After reviewing published data on the impact of *trans* fatty acids on plasma lipid concentrations and epidemiological data on *trans* fatty acid intake and the risk of cardiovascular disease and after considering the health implications of changing the food label vs. the cost of doing so, the Council on Sci-

entific Affairs believed that a fundamental change in food labeling to include specific information on *trans* fatty acids was not warranted at this time. The recommendations, therefore, were 1) Resolution 509 (A-97) not be adopted, and 2) that the CSA monitor the progress of the FDA's November 9, 1998 proposal to amend its regulations and to provide for the declaration of *trans* fatty acids and nutrition labeling and report as necessary.

Resolution 501: Informational Campaign on Diethylstilbestrol

Asks our AMA to encourage education regarding the consequences of diethylstilbestrol (DES) exposure so that medical students and health care professionals receive satisfactory knowledge of the signs and symptoms of DES exposure in both the mother and her children and to support research efforts on DES exposure and the future health of those affected. One concern raised was that women who were treated with DES face uncertain risk as they consider the issue of hormone replacement therapy. Studies of DES progeny remain ongoing. The resolution adopted calls for continued study and education of this issue.

Resolution 509: Increasing Organ Donation

Asks our AMA in collaboration with all other interested parties to support the exploration of methods to greatly increase organ donation, including the “presumed consent” modality of organ donation. Testimony was mixed on this resolution as ethical concerns were raised regarding the various methods to increase organ donation. The adopted resolution resolved that our AMA in collaboration with all other interested parties support the exploration of methods to greatly increase organ donation, such as the “presumed consent” modality of organ donation.

Resolution 513: Reporting Adverse Effects of Drugs, Vitamins, and Herbs and Resolution 521: Herbal Remedies and "Dietary Supplements" - Better Education and Regulation

These resolutions ask the AMA to work with the FDA in educating physicians about the FDA's MedWatch program for the voluntary reporting of adverse events associated with drugs, biologics medical devices, nutritional supplements (dietary supplements, medical foods, and infant formulas), and other FDA related products and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements (e.g. vitamins) and herbal remedies to help support FDA's efforts to create a data base of adverse event information on these forms of alternative/complimentary therapies through MedWatch. Resolution 521 asks our AMA to develop an educational campaign to inform the public and physicians about herbal remedies and dietary supplements and to work with the congress to modify the Dietary Supplement Health and Education Act to require that dietary supplements be FDA approved for marketing, meet FDA post-marketing requirement for reporting of adverse events, and meet USP standards for formulations. Testimony was strongly supportive. The FDA noted that MedWatch reporting is available via phone, (1-800-FDA-1088) and on-line at the FDA's website (www.fda.gov). The substitute Resolution 513 adopted 1) resolved that our AMA work with the FDA to educate physicians and the public about FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complimentary therapies

and 2) resolved that our AMA work with congress to modify the Dietary Supplement and Education Act to require that dietary supplements and herbal remedies, including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; meet standards established by the United States Pharmacopoeia for identity, strength, quality, purity, packaging, and labeling; and meet FDA postmarketing requirements to report adverse events including drug interactions.

Resolution 520: Patient Access to Technologies Pending Approval

The intent of Resolution 520 was to develop a simplified mechanism for improving access to devices for patients who could not qualify for clinical trials. The FDA expressed willingness to work with our AMA on developing mechanisms for enhancing access to devices during their investigational phase for such patients in need. The title of the resolution was changed to "Patient Access to Devices Pending Approval." The adopted resolution resolved that our AMA work with the FDA and the appropriate manufacturers to develop streamline mechanisms, which include adequate safeguards, that will permit patients on an individual case by case basis who have demonstrated (but do not qualify for clinical trials) to have timely access to devices not yet approved but showing reasonable promise for safety and effectiveness.

III. Recommended for referral to Board of Trustees.

Resolution 505: Pain Control During Male Infant Circumcision and Resolution 507: Nontherapeutic Neonatal Male Circumcision Information and Education

These resolutions ask our AMA to study and make recommendations on the issue of pain control during male infant circumcision and to dis-

seminate information to assist physicians in providing medical knowledge about nontherapeutic neonatal circumcision to parents. Testimony noted that the American Academy of Pediatrics and the American Urological Association have guidelines on these issues. Testimony was also heard regarding the benefits of up-to-date information regarding new perspectives on the issues surrounding male circumcision, including new methods of anesthesia. The reference committee, considering the continued controversy, referred these resolutions for generation of an informational report.

Resolution 506: Folic Acid Fortification and Vitamin B12 Deficiency

Asks our AMA to encourage research efforts to identify and monitor those populations at risk for masking Vitamin B12 deficiency through routine Folic Acid supplementation of enriched food products. The CSA is updating a report on Folic Acid which is due for release in six to twelve months. The FDA's rule on folate fortification became effective January 1, 1998 and monitoring data to address effectiveness and safety questions is not yet available. Therefore, this resolution was referred.

Resolution 508: Expediting Pain Control for Terminal Patients

Asks our AMA to lobby congress and drug enforcement agencies to permit the prescription of schedule II medications by fax and electronic data transmission. The testimony was significantly divided on this issue. The benefits of ease of prescription of schedule II medications was contrasted with the potential issue of security and confidentiality vs. other available methods for pain control. Given the level of debate and the important issues of security, misuse of prescription, confidentiality, and protection for both patient and physician, the reference committee recommended referral.

Resolution 510: Guidelines on the Protection of Pregnant Health Care Workers and Their Fetuses from Exposure to Potential Infectious/Teratogenic Agents

Asks our AMA to evaluate the feasibility of developing scientifically based safety guidelines to protect pregnant health care workers and their fetuses from exposure to infectious/teratogenic agents in the health care workplace. The testimony was generally supportive of the referral (especially the intent) with some exceptions. The Nuclear Medicine Section Council testified that exposure to radiation is currently regulated by NRC without documentation of increased risk due to occupational exposure. The organized medicine specialty section requested the AMA evaluate the evidence. Concern was also expressed that singling out pregnant women may lead to discrimination against all women in the workplace who are pregnant and of childbearing age. Considering the aforementioned, the resolution was referred.

Resolution 511: Guidelines for Review of Pap Smears in the Context of Potential Litigation and Resolution 517: Guidelines for Review of Pap Tests in the Context of Litigation or Potential Litigation

Testimony supported the notion that the clinical use of pap smears as an effective screening tool was in jeopardy because of increased litigation concerning false negative readings. Because some elements of these guidelines conflict with current AMA policy and raise legal concerns, the reference committee referred this issue for more comprehensive review of the issues raised by Resolutions 511 and 517.

IV. Recommended for non adoption.

Resolution 503: Use of Automatic External Defibrillators

Asks our AMA to support legislation for the increased use of automatic

external defibrillators (AED) and various competency conditions were recommended. Apparently a number of states have addressed the issue of AED's and first responders with state level legislation. Because there is no data yet on the success of these state programs, the reference committee felt the resolution, although well intentioned, was premature and was not adopted.

Resolution 504: Reclassification of Heroin for Therapeutic Use

Asks our AMA to support research into therapeutic use of heroin as a Schedule 1 drug in the context of addiction treatment for patients for whom other standard methods have been tried and failed. The testimony heard was vigorous and mixed. The American Society of Addiction Medicine opposed the resolution based on the high addictive nature of heroin. A joint AMA-American Bar Association policy paper in preparation addresses a wide range of drug policy issues including heroin maintenance. Therefore, the resolution was not adopted.

Resolution 514: Pharmacy Substitution of Generic Drugs

This resolution asks our AMA to reaffirm existing AMA policy calling for complete explanatory information on prescription labels and to request the FDA administration to require a pharmacy, when it changes between trademark drugs and generics or when it changes generics manufactured for prescription refills, to note that fact on the prescription labels so patient can so inform the physician in case problems arise. Testimony was limited but generally favorable. Importantly, however, it was noted that state boards of pharmacy, not the FDA, regulate pharmacy practice thereby negating the intention of the resolution. (Therefore not adopted).

Resolution 519: Request that the AMA Reconsider its Business Decision to Publish Archives of Facial Plastic Surgery

Asks that the our AMA communicate with section councils and specialty societies within the federation on business decisions that will impact them, ask that the board of trustees direct the representation of the editorial board of the new journal from all involved specialty societies within the federation and assume responsibility in the event that this business venture fails. Also, it asks that if a profit cannot be attained within the first two years of the inception of the journal, that it be discontinued. The issues contained within this resolution were divided into two main areas, 1) a concern about the communication process between the AMA and its components, and 2) a relationship between two complementary yet competing specialty groups. It is anticipated that implementation of new communication procedures adopted by the AMA will insure that appropriate notification will occur for all future activities, and it was recognized that any specialty organization has the right to publish a journal, determine its publisher, and the peer review process for such journals. The reference committee strongly urged all parties to diligently work towards resolving their differences. (Therefore not adopted).

Resolution 522: The Distribution of Organs Retrieved for Transplantation

Asks that policy H-370.990, "Transplantable Organs as a National Resource" be amended to reflect the concept that organs and tissues retrieved for transplantation be considered a local, then regional resource prior to consideration for national distribution. The testimony was fairly extensive regarding local vs. national allocation of donated organs and was consistent with the debate surrounding this issue over the past

year. ACEJA opinion favors national allocation. The proponents of the resolution including transplant surgeons and a number of state delegations argue in favor of local allocation first to protect local OPOs and successful state organ donor programs. Findings suggesting that potential donors are more likely to donate for local use were cited. Opponents of the resolution included ACP-ASIM and the CSA argued against changing AMA's recent opinions on allocation. Debate on both sides of the issue referred to evidence on ischemic time for specific organs and differences between transplantable organs and tissues. Ultimately, the resolution was not adopted. This issue, however, including most appropriate and successful methods of increasing organ donation and most appropriate and successful methods for organ and tissue allocation, distribution, and use does not seem resolved, and I anticipate further resolutions and debate regarding this.

REFERENCE COMMITTEE F BOARD OF TRUSTEES

Submitted by Michael J. Bradley, D.O.

Report of the Ad Hoc Committee on Membership Board of Trustees (BOT) Report 10: Dues Delinquency Date, Resolution 604: Dues Delinquency Date

Reports on 13 recommendations addressing membership recruitment and retention, communications, leadership development and innovative approaches to membership including a life cycle approach. There will be some direct benefit to unified societies forthcoming, in the way of a pilot project on dues reduction. The dues delinquency date will be moved back to March 1, effective in the year 2000.

BOT Report 1: Interim Meeting

Beginning in the year 2002 and thereafter, the Interim meeting of the HOD

will be held in the second or third week of November.

BOT Report 21: Unifying Medicine's Agenda

Recommends that a task force be appointed by the BOT to review proposals addressing the fundamental issues about governance, the role of the HOD in setting policy and the relationship between components of the Federation.

BOT Report 27: American Nurses Association - Official Observer

The American Nurses Association was given non-voting official observer status in the HOD.

Council on Long Range Planning and Development (CLRPD) Report 1: Policy Sunset Report for 1988 Policies

All AMA policies are reviewed at ten year intervals for sunset. Many policies were reviewed and recommendations were made for retention, rescission and retention-in-part of policies originally adopted in 1988.

CLRPD Report 3: Consolidation of Section 350 (Minorities) of the AMA Policy Compendium

Consolidates AMA policy on minorities.

CLRPD Report 4: Strategic Options for Medical Associations

Presents ten recommendations for strengthening the Federation and to implement the work of the Federation Coordination Team (FCT).

Resolution 603: AMA Division of Physician and Patient Advocacy

Supports the Division to fulfill their mission of serving as an advocate for both physicians and patients in our changing health care system. The 1999 AMA Budget has a significant increase in funding for this program.

Resolution 601: AMA Young Physician Loan Program, Resolution 610: Extended Payment Educational Loan Programs

Asks our AMA to further develop and more aggressively publicize a low interest and extended payment loan program for young AMA members.

Ad Hoc Committee on Structure, Governance, and Operations

The reference committee on this item alone took testimony that lasted over three hours. The reference committee reviewed a 28 page report consisting of 36 recommendations. The following is a brief summary. Recommendations 1-4 and 29 deal with strategic planning, risk management and communications. Recommendations 5-17 deal with the roles and functions of the BOT. Its focus should be on the fiduciary and oversight roles and should use the strategic planning process more. The Chair of the BOT would be precluded from immediately succeeding to the position of President-elect. No AMA Officer or Trustee would be eligible to serve as Executive Vice President within three years of having office. Recommendations 18-20 address the role of the AMA President and the AMA appearance program. Whenever feasible the Presidents (current, past and elect) should be the chief spokespersons. The appearance program of the Board is controversial and needs further analysis, to be reported back at the 1999 Interim Meeting. Recommendations 21-24 relate to the HOD, the need for an analysis of how the role and responsibility of the House can be strengthened, especially with regard to the communications role of Delegates. Recommendations 25-28 address the roles of the councils, and support the fine work of the councils. Recommendations 30-36 address the role of the EVP and staff.

A progress report on the implementation of these recommendations will be forthcoming from our AMA.

BOT Report 7: Expanded Fiscal Notes

Resolutions presented to the HOD which have a fiscal note of over \$5000 will specify whether it is a loss of revenue, additional operating expense or savings to the AMA. For each resolution with a fiscal note of over \$50,000, there will be a greater detail and supporting documentation.

BOT Report 11: Opposition to the Release of Individual Prescribing Data

Urges the AMA to continue to monitor and control the licensing of physician prescribing information through the Physician Masterfile; to communicate the physician concern over the use of prescribing data; and to reinforce the AMA's position on restricting the release of any patient identifiers; prohibiting the non-professional use by pharmaceutical representatives; and prohibit the release to third parties.

Resolution 602: Tenure of Reference Committee Members

Asks that members of Reference Committee F serve for two years, on a staggered basis.

Resolution 605: Electronic Voting

Asks that the HOD adopt the electronic method of tabulating votes as soon as possible.

Resolution 606: Medical Savings Account

Asks the AMA to inform physicians and the public about the value and availability of MSAs.

Resolution 612: Availability of AMA Policy and Reports on the World Wide Web

Was referred to the BOT for Decision, regarding the feasibility and timing of the various policies and reports as soon as possible.

BOT Report 6: Physician Income Data

Was referred back to the board with many comments about the lack of

responsiveness of this report. The HOD felt a revised report should be presented to the HOD at the I-99 Meeting.

Resolution 607: Meeting Attire

Was not adopted. The policy of professional attire at the Annual and Interim meetings was upheld, with the exception of the meetings in Hawaii, where local business attire is more casual.

Resolution 609: Concerning the Imprisonment of Dr. Desi Rivero Mendoza

Was not adopted. The AMA has previously issued a letter of intervention to Cuban officials and a response has not yet been received

Resolution 611: Study of Direct Election of AMA Leadership

Was not adopted. This study was not felt to be a pressing priority for the AMA, and that resources would be better directed to other activities.

Resolution 612: Discontinuing Hawaii as a Site for the Interim Meeting

Was not adopted. The misperception that attendance at the Interim Meeting is a junket for delegates should be addressed by educating individuals who hold such views about the work that takes place at this meeting.

BOT Report 23: AMA Strategic Plan and Budget 1999

The report presented the budget for the upcoming year and notes the cost of the Sunbeam settlement.

BOT Report 29: Transmission of the Report of the Federation Coordination Team: Status Update

Is an informational report on the progress of the FCT, the three federation projects the FCT has developed as well as the FCT's thinking on the development of a federation conflict resolution mechanism.

CLRPD Report 2: Demographic Characteristics of AMA Leadership

Is an informational report on the demographic characteristics of the AMA leadership, including the HOD, to encourage and promote diversity when appointing or nominating physicians to leadership positions.

Joint Report - CC&B and CLRPD: The AMA and the Federation of Medicine

An informational report on the perspectives of the councils on several aspects of the federation. The Councils feel the current federation must be strengthened to better serve physicians and their patients.

REFERENCE COMMITTEE G

Report 13: Definitions for "Screening" and "Medical Necessity"

Adopted Council on Medical Service Report 13, which provides for "screening" and "medical necessity" that augment the AMA policy base on medical review. AMA definitions are based on the physician's best judgment, even though insurers currently use the lowest cost among their criteria for these terms.

Report 16: PRO Sixth Scope of Work

Adopted Council on Medical Service Report 16 which describes the proposed PRO Sixth Scope of Work and recommends modifying and updating several policies pertaining to previous Scopes. Also recommended were the elimination of the proposed Payment Error Prevention Program in the Sixth Scope, which includes a "bounty hunter" incentive.

REFERENCE COMMITTEE H

Submitted by Marshall Schwartz, M.D.

Report for the Delaware Medical Society for Reference Committee H (Health Care Data/Systems)

Reference Committee H met on December 7, 1998 during the Ameri-

can Medical Association Interim Meeting. More than 20 resolutions were reviewed along with several Board of Trustees Reports. The following are some of the resolutions that were adopted:

Resolution 803: Medical Staff Legal Counsel and Conflict of Interest

Resolution 803 asked that, from the perspective of legal representation, the hospital and medical staff be considered as separate entities and that it be considered unethical for an attorney retained by a hospital to officially represent the medical staff as its legal counsel without full disclosure of any potential conflict of interests.

Resolution 803 also asked that, when an attorney acts as legal counsel for the medical staff, full disclosure of conflict of interest should be made.

Resolution 808: Conflicting Accreditation Standards Among Various Accreditors

This resolution stipulated that the AMA work with JCAHO, HCFA, state legislatures, regulating agencies, and other accrediting groups to insure that there are not conflicts among standards and interpretation, and that the AMA work to insure that accreditation remain in the private sector, and not become a function of government.

Board of Trustees Report 35

Explains the recent implementation of commercial off the shelf edits of CPT codes by HCFA. The report recommends that the AMA continue to support the activities of the Correct Coding Policy Committee (CCPC) and to urge HCFA to accept CCPC recommendations relating to code edits. The report also calls on the AMA to advocate for appropriate use of CPT codes and guidelines, and to protect the integrity of CPT.

Resolution 804

Deals with the evaluation and management documentation guidelines.

Resolution 804 was among seven resolutions submitted along with the Board of Trustees Report 13. Resolution 804 resolves that the AMA continue to use all appropriate means to oppose any change in AMA position that deviates any of the nine principles outlined in substitute resolution A98-801, especially as it pertains to Item #9 (quantitative formulas and/or numeric values) and Item #3 (providing a safe harbor for physicians whose E & M services are selected for review. It states that such reviews should involve peer review physicians who are able to consider all pertinent information that would help determine that the level of the services reported was correct).

In Substitute Resolution 804 additional guidelines are as follows:

- a. Adopted a "clear and ambiguous" statement that America's physicians have had enough of unfair fraud and abuse enforcement and will not stand for harassment by auditors or false accusations of abuse of fraudulent behavior.
- b. Demanded major changes in Medicare payment reviews and well designed pilot tests of any new E & M guidelines.
- c. Instructed the Board to continue technical assistance to HCFA through the CPT editorial panel to produce simpler, patient-centered, clinically relevant and non-intrusive guidelines.
- d. Directed the Board to continue advancing alternatives to numerical guidelines (e.g., peer review of statistical outliers).

Resolution 819: HCFA Regulation to Eliminate the Critical Role of the Hospital Medical Staff

Resolution 819 asks that our AMA: (1) oppose HCFA's proposed regulation to eliminate 42 C.F.R. 482.22 Conditions of Participation: Medical Staff; (2) support the position that the medical staff is the uniquely qualified organization to report to the govern-

ing body on all aspects of hospital operations impacting patient care; and (3) adopt and implement a strategic plan to assure that HCFA does not eliminate 42 C.F.R. 482.12 Condition of Participation: Governing Body, which outlines the requirement that a medical staff be accountable to the governing body for the quality of patient care provided to patients.

Board of Trustees Report 4: Diagnostic Procedural Coding System (Resolution 815, A-98)

Board of Trustees Report 4 responds to Resolution 815 (A-98), which called on the AMA to preserve the coding authority of professional services and to arrange Current Procedural Terminology (CPT) hierarchically to allow for systematic statistical aggregation. The resolution also asked the AMA to evaluate the appropriateness, costs and implementation of the proposed ICD-10-PCS developed by the 3M Company.

The report concludes with four recommendations. First, that the AMA continue to monitor developments regarding ICD-10-PCS, that the AMA continue to work on development of CPT-5, that Policy H-70.971 be reaffirmed, and that the AMA inform physicians and other users of CPT about the development of CPT-5 and provide progress reports, as they are available.

Resolution 802: Rebundling by Payers, Resolution 815: Downcoding and Bundling of Claims

Substitute resolution 802 asks the AMA to vigorously oppose the practice of unilateral, arbitrary downcoding and/or bundling by all payers; make it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards; formulate a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally downcode or inappropriately bundle physician services, and

support legislation to accomplish this; and along with medical specialty societies, call on their members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

Resolution 813: Limitations on the Use of Modifiers 54 and 55

Resolution 813 asks the AMA to support limitation of surgical co-management to circumstances that focus on the well-being of the patient and not the financial relationship between providers; and the ethical implications of surgical co-management be studied by the Council on Ethical and Judicial Affairs (CEJA) with a report back to the House of Delegates at the Annual 1999 meeting.

Resolution 822: Definition of Consultation: HCFA vs. CPT 4 Coding Manual

Resolution 822 requests that the AMA and the Federation make known to HCFA that redefining consultation to achieve cost savings is unacceptable to the medical profession; that if necessary the AMA seek regulatory and/or legislative relief to overcome this regulatory decision on the part of HCFA; and that the AMA urge the CPT Editorial Panel to review the CPT definitions for consultation and make any needed clarifications.

AMA'S YOUNG PHYSICIAN SECTION

Submitted by Michael S. Katz, M.D.

The American Medical Association's Young Physicians section held its interim assembly meeting on December 3-5, 1998 in Honolulu. The AMA-YPS Assembly is composed of delegates representing their constituent state medical societies, specialty societies, and branches of the uniformed services. Representatives are AMA members and are

under the age of 40 or have been in practice less than five years if they are over the age of 40.

The following summarizes resolutions presented for debate and voted on by the AMA-YPS Assembly:

Autonomous Medical Practice of Non-physicians

Referred to the governing council for decision asking the AMA to continue to actively oppose legislation allowing non-physician groups to encroach on the practice of medicine without physician training or appropriate physician supervision; study and report back on the definition of the practice of medicine including the role and scope of practice of physicians and non-physicians.

Guideline to Protect Pregnant Health Care Workers and Their Fetuses from Exposure to Potential Infectious/Teratogenic Agents

Asks the AMA to evaluate the feasibility of developing scientifically based safety guidelines to protect health care workers and their fetuses from exposure to infectious/teratogenic agents in the health care workplace.

AMA Young Physician Loan Program

Asks the AMA to further develop and more aggressively publicize a low interest and extended payment loan program for young physician members of the AMA to assist them in retiring their educational debts.

School Bus Safety

Asks the AMA to reexamine, in conjunction with appropriate agencies, the issue of school bus safety, including accident related morbidity and mortality as well as non-accident related morbidity and mortality and to report back at I-99.

Anesthesiology is the Practice of Medicine

Asks the AMA to support efforts by state medical associations and specialty societies to establish the principle in federal and state laws and

regulations that the delivery of anesthesia care constitutes the practice of medicine.

Medical Competency Examinations

Asks the AMA to review and propose improvements for assuring continuing physician competence, including but not limited to performance indicators. Board certification and recertification, professional experience, continuing medical education and teaching experience.

The Relationship Between Physicians, HMOs and Drug Companies

Asks the AMA to adopt as internal policy Council on Ethical and Judicial Affairs Opinion 8.061, "Gifts to Physicians from Industry" and HOD Policy 140.973 "Gifts to Physicians from Industry" and request that CEJA address the issue of health care organizations accepting monetary benefits from Industry.

Medical Office Visits, Therapy Sessions, and Injections

Asks the AMA to work with the Health Care Financing Administration and with third party payers to streamline the process of obtaining appropriate reimbursement for medically necessary injections given at the time of the visit and advocate that physicians be informed of the mechanism that HCFA has to resolve reimbursement issues through the HCFA Fair Hearing Process.

Restrictions on New Adolescent Drivers

Asks the AMA to develop model state legislation developing "Graduated Driving Laws" which will require adolescents to obtain a provisional driving license and a collision-free driving period prior to obtaining an unrestricted drivers license; require experienced adult supervision for adolescent drivers during the provisional driving period; and limit the number of adolescent passengers in vehicles driven by adolescents to no more than the number of seat belts in the vehicle.

On Call Physicians

Asks the AMA to study recent trends in the reimbursement, responsibilities and availability of on-call physicians and the impact of these trends on the timely delivery of emergency services.

Patient Access to Technologies Pending Approval

Asks the AMA to work with the FDA and the appropriate manufacturers to develop streamlined mechanisms, which include adequate safeguards, that will permit patients on an individual case-by-case basis who have demonstrated need to have timely access to technologies not yet approved, but showing reasonable promise for safety and effectiveness.

Addressing House of Delegates Business in the Absence of formal YPS Position

Allows the AMA-YPS Governing council to take a position on any issue for which there is no clear Section Policy for the purpose of representing the YPS in debate on that specific issue and the governing Council may take such a position only by a two-thirds vote of the entire Governing council during an AMA annual or interim meeting; requires a summary of any positions taken in this manner to be expeditiously disseminated to all assembly members after the decision.

Governing Council Report E

AMA-YPS Strategic Plan: the 1999-2001 strategic plan will be posted on the AMA-YPS website.

If you wish to learn more about the Medical Society of Delaware's Young Physicians Section, or the AMA-YPS, and how you may participate, please contact Mary LaJudice (302) 658-7596, or Kelly Eschbach, M.D., Chair MSD-YPS (302) 428-6600. The next meeting of the AMA-YPS will be at its annual assembly meeting, June, 1999 in Chicago.

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Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting.

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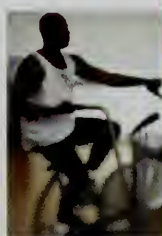
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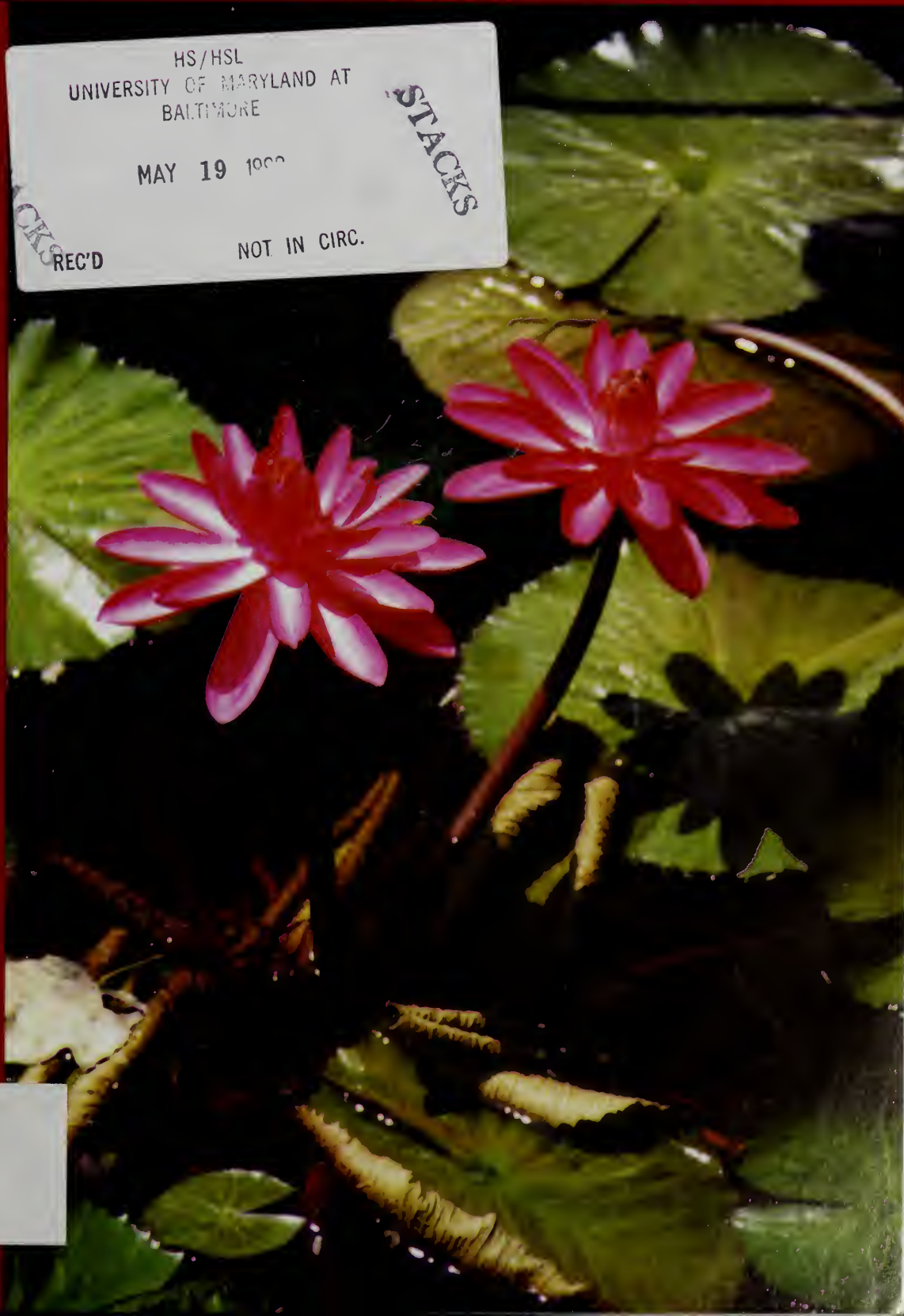
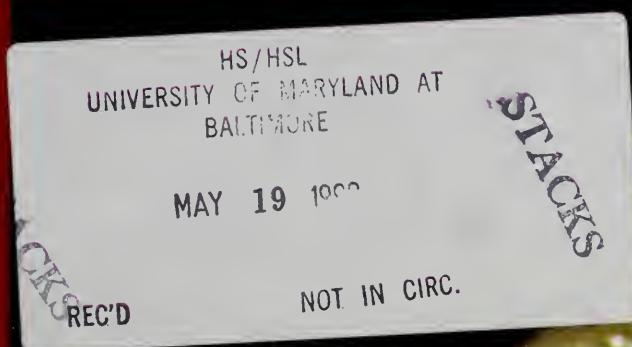
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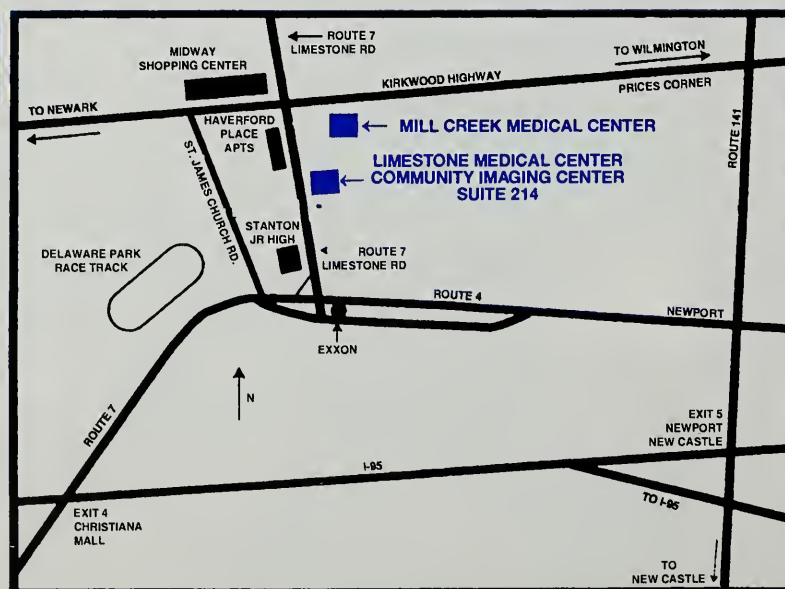
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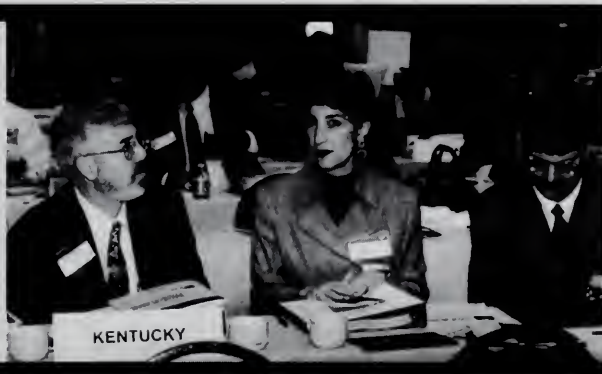
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For more information on how to register, call 800 626-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at omss@ama-assn.org.

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All material for publication should be submitted on a 3 1/2" computer diskette in Word 6.0. A printout of the manuscript must accompany the disk. Manuscripts may also be submitted in paper form (typed or printed out on good-quality paper - one side only, one-inch margins), though computer disk is preferable. The ideal manuscript length is two to 12 pages with up to 12 references, each keyed with superscripts in the text in the order cited. The format should follow that used in the *Index Medicus*. Authors are responsible for the accuracy of the citations.

Graphs, charts and black-and-white glossy photographs are accepted if important to the understanding of the text, but should not exceed four or five pieces. Each should have a label affixed on its back indicating its name, number, and "top." A separate legend should be provided for each. Do not write on the back, or scratch or mar them using paper clips. Do not mount them on cardboard.

Photos of patients should generally be taken in a way that obscures the patient's identity. Photos in which a patient's face must be clearly seen, however, must be accompanied by signed release forms.

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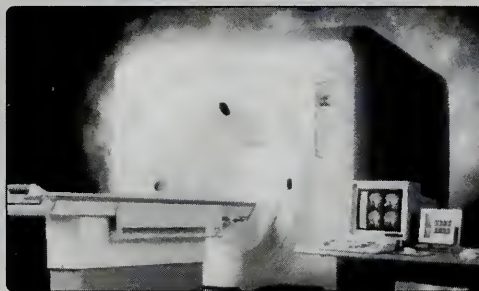
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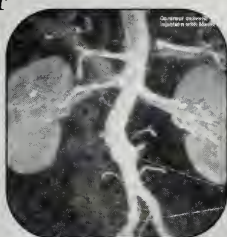
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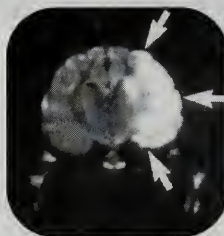
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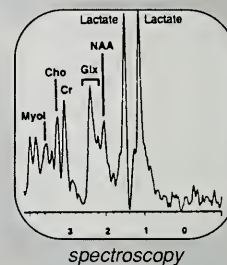
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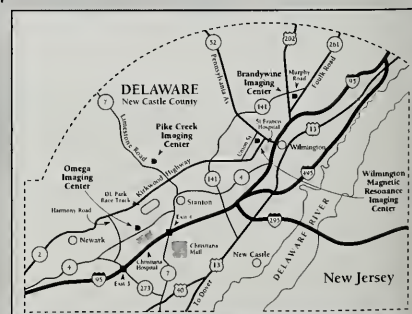
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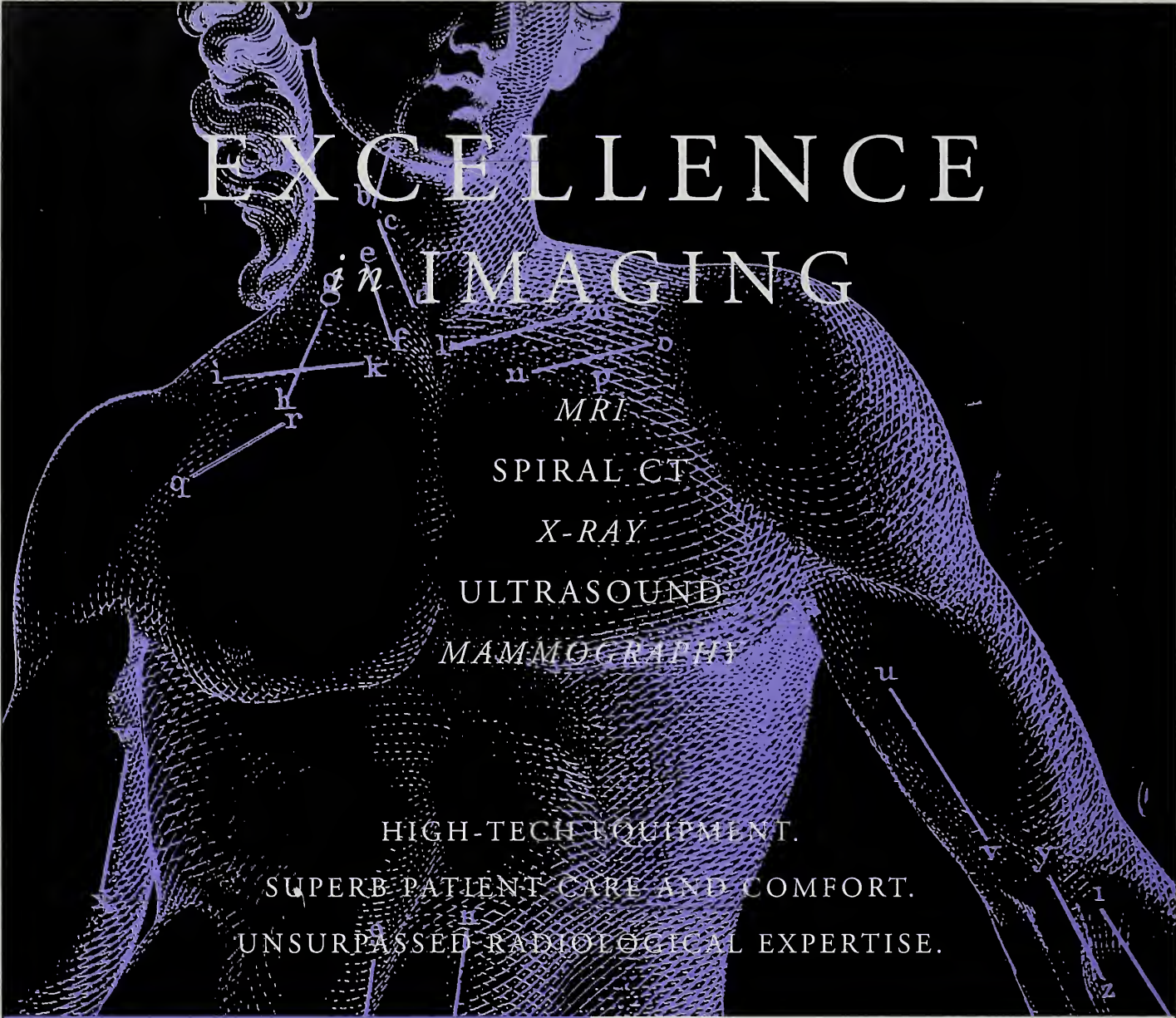
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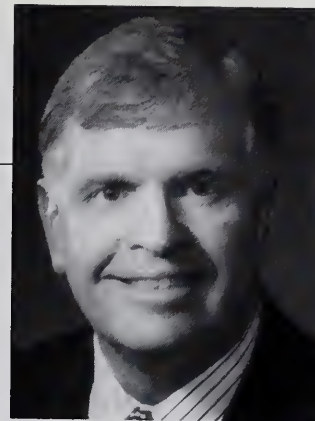
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Martin G. Begley, M.D.



During medical school, our professors taught us to keep abreast of new developments in medicine so we could always give the best care to our patients. They assumed that all of the changes affecting medicine would come from clinical and laboratory research. They couldn't foresee the changes that would occur from outside medicine, especially, the insurance industry.

Today, physicians must effectively deal with these new developments if they are to give their patients optimal care. As you well know, many of these changes have not helped patients. Your Medical Society monitors them, seeks fair solutions, and we are happy to report that there are two bills before our state legislature that would provide patients with essential protections.

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, DE. He is the president of the Medical Society of Delaware.

Senate Bill 48 (SB48), introduced by Senator Patricia Blevins (D-Elsmere), would require medical directors of all health insurance companies doing business in our state to be fully licensed to practice medicine in Delaware. Senate Bill 53 (SB53), introduced by Senator Sokola (D-Newark), would hold insurance companies legally liable for decisions they make.

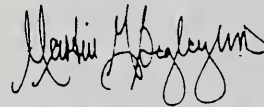
Both of these bills are essential protections for Delaware citizens. Medical insurance companies increasingly intrude into health care by altering or denying the therapeutic and diagnostic prescriptions of patients' personal physicians. Delaware citizens need the assurance that the medical directors of these companies can pass the most basic test of competency — state licensure. Additionally, these companies have to be held legally liable for these intrusions into patient care.

The medical insurance industry is poised to vigorously fight both of these bills, as they have done in other states and lost. They claim that it is too burdensome for them to have their medical directors licensed because some medical directors may have to hold more than one state license. This is a ridiculous argument. Many private practice physicians hold licenses in more than one state. If insurance companies can't manage a few physicians' licenses, how do they claim to be able to manage care? Perhaps they are afraid that their medical directors can't pass muster with Delaware's Board of Medical Practice.

Health insurers will fight even more vigorously to escape legal accountability for their actions hoping you, the practicing physician, will continue to bear the liability for their mistakes while they claim immunity under ERISA. They have to be forced to accept their legal responsibilities. Additionally, SB53 is modeled after a law recently passed in Texas and which was upheld after a challenge in federal appeals court in which the insurance company claimed ERISA

protection. A different federal district court decision has also upheld patients' rights to sue their health insurer. And recent Supreme Court decisions have honored a citizen's right to sue even the President of the United States. How can insurance companies claim to be above the law? Finally, other states are adopting similar legislation to protect their citizens' rights.

Senator Blevins and Senator Sokola are demonstrating tremendous dedication to the best interests of their constituents, and all Delawareans, as well as profound personal courage in introducing and fighting for this legislation. They deserve our full and vigorous support. Call your Representative and Senator to express your support for this legislation and inform your patients of the threats they face if this legislation is not passed.



Martin G. Begley, M.D.
President

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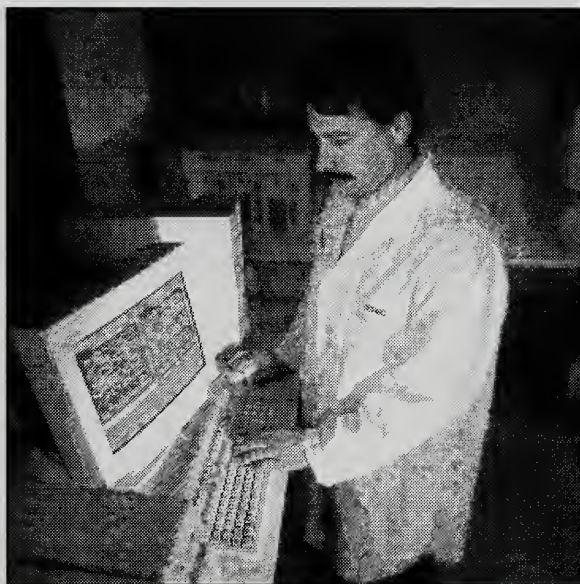
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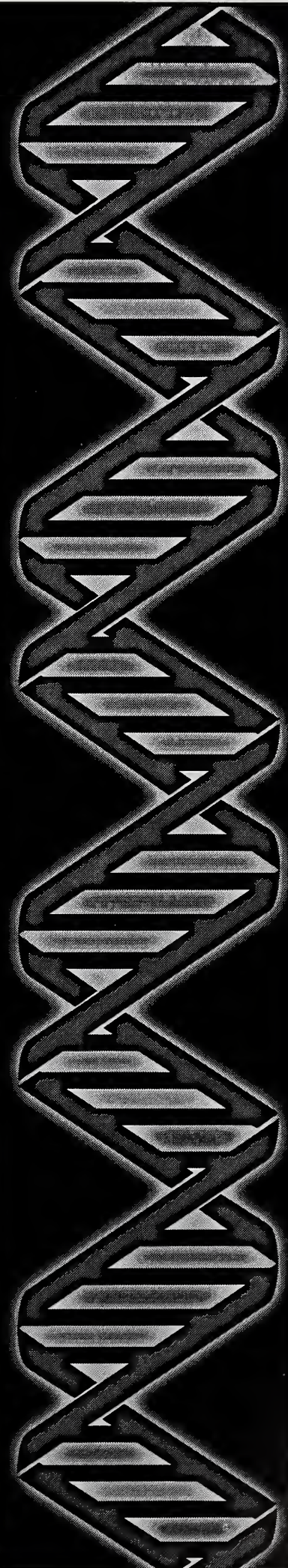
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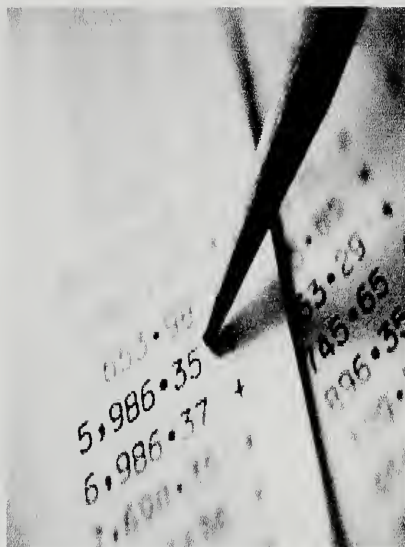


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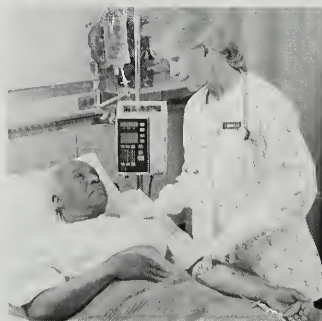
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Adult Onset Still's Disease Presenting as Aseptic Meningitis in a Young Healthy Female

Stephen G. Sisselman, D.O.

Abstract. A 20-year-old white female presented with symptoms of upper respiratory tract infection, meningeal signs, rash, and fever. Initial laboratory data revealed a leukocytosis and abnormal CSF. An initial working diagnosis of the Aseptic Meningitis Syndrome was made. She did not respond to antimicrobial therapy. All culture results and viral titers were negative. One week into her hospital course, the diagnosis of Adult Onset Still's Disease (AOSD) was made. Antibiotics were discontinued and nonsteroidal anti-inflammatory drugs (NSAIDs) begun. The patient showed marked improvement within 24 hours. This case reveals that AOSD is an important consideration in the differential diagnosis of Aseptic Meningitis. Meningeal signs and abnormal cerebrospinal fluid (CSF), both detected in this patient, are very rare occurrences in Still's disease.

INTRODUCTION

Adult Onset Still's Disease (AOSD) is a systemic inflammatory disease of uncertain etiology. Bywaters first described AOSD in 1971 as a condition with features identical to those found in juvenile rheumatoid arthritis.¹ A spectrum of symptoms and signs exists, with fever, rash, arthritis, and arthralgias being the most common.^{2,7} Sore throat is another frequent manifestation, and is also an extremely common presenting complaint.³ As no serologic test exists to confirm or rule-out the diagnosis, a patient with AOSD is often diagnosed by meeting various clinical criteria. No uniformly accepted criteria exist, but many authors have published clinical guidelines.^{2,4,5} Central nervous system (CNS) involvement in AOSD is a rare finding,

and is not part of a recently published collection of six sets of clinical criteria.⁵ This case illustrates a patient who meets clinical criteria for AOSD and who initially presented with the Aseptic Meningitis Syndrome and abnormal CSF.

CASE REPORT

A 20-year-old white female presented to our institution in July 1997 with a two-week history of headache, stiff neck, photophobia, high fevers, sore throat, non-productive cough, dyspnea, myalgias, arthralgias, nausea, and vomiting. She had seen her family physician one week earlier, where she had similar complaints and a negative chest x-ray. Doxycycline was begun at that time. When she became ill, she had been living in West Virginia with her boyfriend, with whom she had been sexually active. Recent

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exposures included pet parrots and dog urine from her sick puppy. She denied any recent travel, contact with insects, sick persons, or fresh water streams.

On presentation, she had not improved after treatment with Doxycycline, and she had felt worsening symptoms of stiff neck, sore throat and joint pains. Physical exam revealed a febrile, tachycardic, lethargic, toxic appearing person with meningeal signs, pharyngeal erythema, synovitis of the wrists and ankles, abdominal tenderness, and an erythematous macular rash on her extremities and back. Neither hepatomegaly nor splenomegaly was appreciated.

Initial laboratory data showed serum white blood cell count (WBC) $12 \times 10^9/l$ with 75 percent neutrophils, and hemoglobin 11.0 g/dl. The CSF showed 200 WBCs per mm^3 with 80 percent neutrophils, glucose 57 mg/dl, and protein 72 g/dl (normal 15-45). No organisms were visualized on a gram stain of the CSF. Electrolytes and transaminases were normal. MRI of the neck, performed to rule out paravertebral abscess, showed only anterior cervical adenopathy. CT scans of the brain and a chest x-ray were both read as normal studies.

Admission diagnosis was aseptic meningitis of undetermined etiology, and antibacterial treatment was begun. Initial antibiotic therapy was started with Cefotaxime and Doxycycline. This was changed three days later to Chloramphenicol and Azithromycin after no response to treatment was noted. Diflucan was added two days later to cover fungal organisms. Serologies for Rocky Mountain spotted fever, human immunodeficiency virus, Lyme disease, leptospirosis, psittacosis, ehrlichiosis, and parvovirus B-19 were negative. Urine antigen for Legionella was negative. Pharyngeal and stool viral cultures were negative. Cultures for Neisseria gonorrhea were negative. Immunological work-up, including ANA, RF, anti-double-stranded DNA, C-ANCA, anti-Ro (SS-A), and anti-La (SS-B) was negative. A pregnancy test and RPR were also negative. Complement levels were not decreased. A repeat chest x-ray revealed bilat-

eral pleural effusions. A second CSF examination was unchanged from the first, showing pleocytosis of mostly neutrophils and moderately elevated protein. Joint aspirates of the wrist and knee were obtained and gram stains were negative.

Quotidian fevers spiking to over 103 degrees Fahrenheit each morning and evanescent rash appearing with the fever spikes persisted. Dermatographism was demonstrated. Despite broad-spectrum antimicrobial coverage, she continued to demonstrate lethargy, stiff neck, arthralgias, persistent spiking fever, synovitis, and sore throat. The diagnosis of possible AOSD was suggested. Antibiotics were discontinued and salicylate 2250 mg/day in divided doses was begun. The patient defervesced and showed marked improvement 24 hours after beginning salicylate therapy. She was discharged from the hospital, and outpatient follow-up with a rheumatologist was initiated. Since then, she has remained afebrile and experiences minimal joint complaints on nonsteroidal therapy.

DISCUSSION

Adult Onset Still's Disease is a systemic inflammatory disorder of unknown etiology, which has been described in many case reports and investigational studies over the last three decades. The effects of this disease can be felt in almost every organ system. In addition to the extremely common nonspecific complaints of fever, rash, arthralgia and arthritis, patients often have complaints indicative of further systemic dysfunction. Some of these include muscle involvement, adenopathy, organomegaly, abdominal pain, pericarditis, pleuritis, as well as CNS, renal, and hematogenous disease.^{2,3,7,10}

The laboratory features are nonspecific. No serologic test exists to confirm the diagnosis. Increased erythrocyte sedimentation rate, leukocytosis with neutrophilia, and a normochromic normocytic anemia are often found.^{2,4,5,7,10} The transaminases may be elevated, and this may be due to either the systemic inflammatory nature of the disease or as a reaction to salicy-

late therapy. Hyperferritinemia is often seen in Still's disease. In some cases the levels are in excess of ten times normal. These levels are higher than usually anticipated as acute phase reactants. It is hypothesized that these exceedingly high levels of ferritin reflect the presence of histiocytic hyperactivity that sometimes may lead to a hemophagocytic syndrome.¹¹ Almost invariably, antinuclear antibodies (ANA) and rheumatoid factor (RF) are not elevated. There is an association with histocompatibility antigens. The loci of HLA-B8, Bw35, B44, DR4, DR5 and DR7 have been reported in Still's disease patients, but these associations are entirely nonspecific and should not be used for prognostic or diagnostic information.⁷ An attempt should be made to rule out infectious processes mimicking the manifestations found in AOSD. To date, no specific bacterial, viral or other organism has been consistently isolated from sera of affected patients. One recent study has suggested that Echovirus 7 and Rubella may be responsible for triggering AOSD in a group of patients, but this has not been confirmed.¹²

There are certain radiographic abnormalities common to patients with AOSD. Periarticular demineralization is commonly found in many joints. The wrists are particularly susceptible to ankylosis seen in the carpal-metacarpal joints as a long-term sequela. In severe cases, bone destruction may be visible on x-ray.

As discussed earlier, the diagnosis of AOSD is based on satisfying clinical criteria. Some authors have developed major and minor criteria for establishing a diagnosis. Reginato and Yamaguchi include fever, leukocytosis, typical rash, and articular involvement as major criteria.^{4,5} A collection of minor criteria exists, endorsed by some investigators, which includes sore throat, lymph node involvement, splenomegaly, hepatomegaly, liver dysfunction, serositis, negative ANA and RF, and hyperferritinemia.^{4,5,11} Sore throat is not present as often as fever, rash, or articular involvement. However, sore throat has often been reported to be a presenting symptom of AOSD, and may correlate with febrile episodes and disease flares.¹¹

Absent from any of the criteria for the diagnosis of Adult Onset Still's Disease is CNS involvement. CNS manifestations are relatively rare, and have been reported in less than seven percent of cases of AOSD.^{2,7,8} Pouchot et al described two patients in his series who developed disorientation and confusion in association with hepatic failure.¹³ Reginato also described patients with CNS dysfunction, but attributed these changes to drug toxicity associated with the treatment for AOSD, namely nonsteroidal anti-inflammatory drugs, steroids, and cytotoxic medications.² Most of the reported cases of AOSD with meningeal signs have shown normal CSF. There have been previous cases of abnormal CSF reported in patients with AOSD, but these cases had additional nervous system manifestations such as peripheral neuropathy and focal brain lesions.^{6,8}

Our patient has an interesting differential diagnosis. The Aseptic Meningitis Syndrome is often seen in patients presenting with fever, headache, stiff neck, photophobia, nausea, vomiting, lethargy, and arthralgias, as seen in our patient. The common causes of this clinical picture are well known and include enteroviruses, mumps virus, and other infectious agents such as bacterial, fungal, mycoplasmal, rickettsial, and spirochetal etiologies. Malignancy, collagen-vascular diseases, and medications are other common causes.¹⁴ Our patient had been given Doxycycline as an outpatient. Although this was appropriate treatment for a number of possible causative agents, including Rocky Mountain Spotted Fever, it enabled partially treated bacterial meningitis to be considered strongly as a diagnostic possibility. In these cases, bacteria may not be visualized during Gram stain or on culture of CSF, and the white blood cells may be more mononuclear than expected with acute bacterial meningitis.¹⁵ Since our patient had been sexually active, Disseminated Gonococcal Infection (DGI) was considered. DGI can present as a systemic polyarthritis and with meningeal signs.

The patient described in this case had a thorough work-up for infectious, neoplastic, connective tissue, and other causes of the Aseptic

Meningitis Syndrome, and all results were negative. The diagnosis of AOSD was made only after our patient did not show any improvement to broad-spectrum antimicrobials, and improved dramatically after a trial of salicylates. Our patient met the clinical criteria for Adult Onset Still's Disease established by many authors.^{2,4,5} This case illustrates the interesting and broad differential diagnosis of the Aseptic Meningitis Syndrome, and that AOSD needs to be considered in any patient presenting with unexplained fever, rash, arthralgias, and meningeal signs.

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Medical Text Books on the World Wide Web

Brett Elliott, M.D. — Gwendolyn Elliott, M.L.S.

The availability of medical textbooks for physicians on the web is rapidly increasing. Internet sites that maintain a listing of such resources are briefly described, and descriptions of particularly valuable fee based and free medical textbooks web sites are categorized.

Medical textbooks available on the web are proliferating and they take a variety of forms. Some are print textbooks that have published online versions, some are those that began as web sources that are now also available in print form, and then there are those that are exclusively available on the web. Most sites are free; however some do charge for using their references. The availability of these resources is rapidly changing and it would be difficult to list all the medical textbooks available online. Consequently, the most valuable portion of this article is the segment that catalogues web sites that have a section devoted to listing online

textbooks. Section two describes two sites that are fee based, and the final section lists free resources.

For a reference to be included in this paper, the following has to be obvious: the source of the publication, information about the author such as affiliations and proprietary interests, revision dates, and peer review. Comprehensiveness is important as a textbook implies an extensive review of a topic as opposed to what one might expect in a journal article. Some sites added their privacy policy. In searching medical databases, this takes on an added significance because of confidentiality issues. For textbooks that charge an access fee to be included in this paper, a free trial period was required. This gives individuals an opportunity to evaluate the reference from their perspective, and insure that the web site is readily accessible when needed regardless of the time of day.

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Gwendolyn Elliott, M.L.S., is a Medical Librarian at Bayhealth Medical Center, Milford Memorial Hospital, Milford, Delaware.

SITES FOR FINDING MEDICAL TEXTBOOKS

The Doctor's Reference Site

<http://www.drsref.com.au/books.html>

This site consists of two sections; one catalogues textbooks which are free, and the second section lists sites which charge for access. Approximately 20 sources are indexed.

Health Science Center of Emory University

<http://www.MedWeb.Emory.Edu/MedWeb/default.htm>

Emory University sponsors this site, and on their search menu typing in "textbooks" yielded seven references.

Martindale's Health Science Guide

<http://www-sci.lib.uci.edu/HSG/Medical.html#MCTM>

The University of California hosts this site, and it contains a large, eclectic collection of medical information. The section on Medical Courses, Textbooks, Modules and Cases is arranged by subject matter and a variety of sources are listed in each area. There is considerable variation in contents from one clinical area to another. Many of the listed web sites are medical schools and at them one can find resources such as house staff guides, physical diagnosis handbooks etc. For example, in the Physical Exam section there were links to the University of Florida College of Medicine where physical diagnosis study guides are online.

Medical Matrix

<http://www.medmatrix.org/SPages/Hypertextbooks.asp>

Jump to the "Textbooks Section," where online books and reference material is catalogued. Currently there are approximately 40 listings, and all are rated, have a brief description, and are hypertexted.

FEE BASED SITES

Many of the "Bibles" can be found on these sites. Searching is generally rapid, as no ongoing, graphic intensive, advertising is present, and the only significant graphics are tables or pictures in the book itself. Usually a free trial period is offered so one can evaluate the site prior to paying for it. Some medical schools and

hospital libraries sponsor these sources, and so free access may be available to those who qualify via an appropriate affiliation.

Harrison's Online

<http://www.harrisonsonline.com/>

A year of unlimited access for one individual is \$89.

The chief resource of this site is the 14th edition of Harrison's Principles of Internal Medicine. One can search the book in a variety of ways and it is easy to jump to related subjects through hypertexting. There are sections on updates, late-breaking clinical trial data, new references, links to related web sites, and self-assessment questions. The sources are somewhat integrated. For example, the ACE Inhibitor Clinical Trial is hypertexted to Chapter 243, which is the section on Acute Myocardial Infarction. Certain pages and articles can be downloaded for quick future reference. The site also has atlases of dermatology, endoscopic findings, ocular pathology, and hematology. Searching was fast at a variety of times of the day.

MD Consult

<http://home.mdconsult.com/das/booklist/view>

The three founding publisher-partners of MD Consult are Lippincott Williams & Wilkins, Mosby-Year Book, and W.B. Saunders Company.

This is a large, fee-based site with access to over 37 medical textbooks. A variety of plans are available for the individual ranging from a year of unlimited use for \$199.95 to 24 hours of unlimited use for \$6.95. Generally the latest edition is available online within several weeks of publication, and the text is complete. Some illustrations in the printed version are not available online, as the site said current copyright agreements with certain sources limited online use. In future editions this is to be corrected.

Mainstays such as Lee: Wintrobe's Clinical Hematology, Bennett: Cecil Textbook of Medical Therapeutics, DeVita: Cancer: Principles and Practice of Oncology, and Behrman: Nelson Textbook of Pediatrics are online. Representative specialty mainstays include Walsh:

Campbell's Urology Middleton: Allergy: Principles and Practice, Sabiston: Textbook of Surgery, and Braunwald: Heart Disease: A Textbook of Cardiovascular Medicine. Also at this site are many full text articles from 48 medical journals including the Clinics of North America. There are sections on practice guidelines and drug information. Fast searching was the rule during different times of day.

FREE SITES

On these sites, searching was frequently slower than at the fee based sites. Speed can be related to the fact that often advertising is graphic intensive and downloaded before information content. This is less problematic if one has access to a line over 56 K and the search is not during high volume times of the day.

Diagnostic Procedures Handbook

<http://www.healthgate.com/dph/html/index.shtml>

This handbook describes 294 procedures. Generally for each one, common synonyms are given, what the procedure applies to, what it includes, indications and contraindications, and general patient preparation and educational considerations. For some simple procedures, there is information on technique. Entries generally have references, but often they are not hypertexted. For some procedures normal and critical values and appropriate turn around times are given.

Diagnosis and Management of Asthma, 2nd edition

<http://www.medscape.com/PCI/asthma/public/asthma-about.html>

This book provides a condensed yet comprehensive review of all aspects of asthma from basic definitions and classification through diagnosis and treatment of the variety of forms of the disease. The use of bronchodilators and anti-inflammatory agents and their dosages are discussed and the anti-leukotriene drugs are reviewed. The Report of the Second Expert Panel of the National Asthma Education and Prevention Program (NAEPP) (1997) is presented in detail. There are images files of inhalers, spacer devices, and peak flow meters.

emedicine

<http://www.emedicine.com/emerg/index.shtml>

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This site is committed to the development of free, online medical textbooks for use by medical practitioners. There is unlimited downloading of text and graphics which include illustrations and x-rays. Currently Dermatology, Emergency Medicine, Medicine and Surgery, Neurology, Ophthalmology and Pediatrics are under development. As of 3/99, only the book on emergency medicine is close to completion and the others are generally in their early stages of development. The site is soliciting for authors, and welcomes new illustrations to areas that are completed. Articles in the ER book are by a variety of individuals. Authorship, peer review status etc. for each article is obvious. This is a useful resource; however except for the ER section much of it is still a work in progress.

Hosford Medical Terms Dictionary

http://www.ptcentral.com/university/medterms_zip.html

This dictionary has approximately 10,000 medical terms and can be integrated into popular word processing dictionaries. The author offers it as downloadable shareware and requests a \$2.00 payment. It was a big help in writing this paper!

Medical Microbiology: Fourth Edition

<http://129.109.136.65/microbook/>

The entire 1996 edition is online. The individual chapters are by a variety of authors and Samuel Baron, M.D., from the University of Texas Medical Branch edits it. This is an extensive clinical guide to microbiology with textural information and many illustrations. There is an overview section, and then sections devoted to bacteriology, virology, mycology, parasitology, and infectious disease by organ system. This is a valuable reference for both the clinician and pathologist.

Medical Economics Company, Inc.

<http://www.pdr.net/physician/index.htm>

Registration is required for this site and you need your DEA number. The PDR is online and

many of the words in the PDR are hypertexted to Stedman's Medical Dictionary so looking up a term is quite easy. In addition, the Red Book, Stedman's Medical Dictionary, and several directories are available at this site.

Outlines in Clinical Medicine - Physicians' Online

http://home.po.com/cgi-bin/pol_www/signon/signon.cgi

The Outlines in Clinical Medicine is a computer-based medical information system on internal medicine focusing on capsular topical summaries. It is updated quarterly, and according to the author it is used at Harvard Medical School. Over 700 conditions are covered. The topics are in outline form, quite current, and generally will have succinct summaries covering the diagnosis, treatment, and other salient points.

Taber's Cyclopedic Medical Dictionary, 18th Edition

<http://ipn.intelihealth.com/ipn/ihIPNTabersMain>

One has to register; however it is currently free. This dictionary is easily searchable, and tables and appendices are included.

Virtual Hospital Multimedia Textbooks

<http://vh.radiology.uiowa.edu/Providers/Textbooks/MultimediaTextbooks.html>

In this section, there is approximately 25 listings and topics range from Infectious Diseases of the Central Nervous System to an in-depth discussion on the management of Congenital Clubfeet. There are a large number of clinical slides and/or radiograph liberally interspersed throughout the text. Most likely the commonest cited reference at this site is The University of Iowa Family Practice Handbook 3rd Edition, A

Table 1. Web site URLs included in this paper

Medical Text Books on the World Wide Web

The Doctor's Reference Site

<http://www.drsref.com.au/books.html>

Health Science Center of Emory University

<http://www.MedWeb.Emory.Edu/MedWeb/default.htm>

Martindale's Health Science Guide

<http://www-sci.lib.uci.edu/HSG/Medical.html#MCTM>

Harrison's Online

<http://www.harrisonsonline.com/>

MD Consult

<http://home.mdconsult.com/das/booklist/view>

Diagnostic Procedures Handbook

<http://www.healthgate.com/dph/html/index.shtml>

Diagnosis and Management of Asthma, 2nd edition,

<http://www.medscape.com/PCI/asthma/public/asthma-about.html>

emedicine

<http://www.emedicine.com/emerg/index.shtml>

Hosford Medical Terms Dictionary

http://www.ptcentral.com/university/medterms_zip.html

Medical Microbiology: Fourth Edition

<http://129.109.136.65/microbook/>

Medical Economics Company, Inc.

<http://www.pdr.net/physician/index.htm>

Outlines in Clinical Medicine

Physicians' Online

http://home.po.com/cgi-bin/pol_www/signon/signon.cgi

Taber's Cyclopedic Medical Dictionary, 18th Edition

<http://ipn.intelihealth.com/ipn/ihIPNTabersMain>

Virtual Hospital Multimedia Textbooks

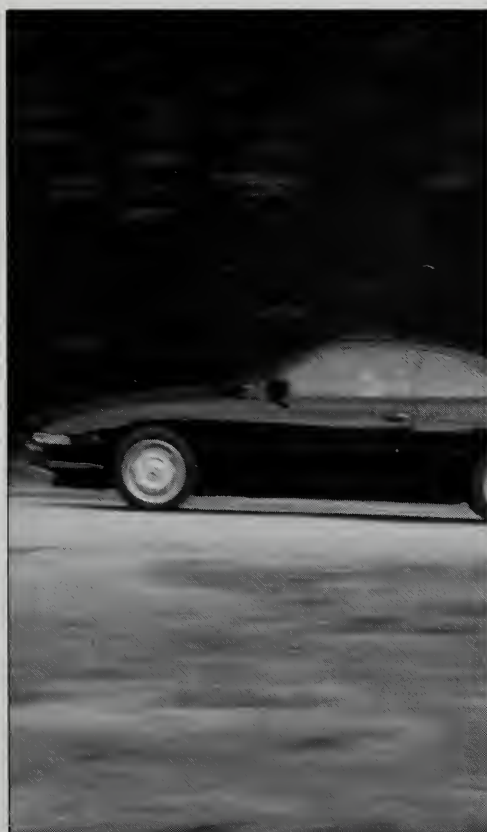
<http://vh.radiology.uiowa.edu/Providers/Textbooks/MultimediaTextbooks.html>

Mosby Handbook. Included is a chapter on often-performed medical procedures such as the placement of a central line. There is a section on medications with dosing schedules and capsular summaries of commonly prescribed drugs.

CONCLUSION

Web-based medical textbook resources for physicians are rapidly increasing. The two fee-based sites offer the latest editions of world renowned resources at an expenditure significantly less than what they would cost in print form. Searching these sites and downloading pages was rapid with a 56 K modem. Academic sites are putting more of their educational material online, such as fourth year medical student and resident handbooks and study guides. Pharmaceutical firms are sponsoring sites that offer free, comprehensive material specifically designed for the web.

These resources are representative of an evolving form of web medical textbooks. As web band width and computer capabilities increase, the availability of multimedia in textbooks will become common. The integration of sound, still photos, and video should facilitate integrated learning. When reviewing medical topics it should be possible to read a text, hear a lecture, see the slides the lecturer was using, plus access full motion video in an integrated fashion. One should be able to visit other germane reference sites, and in the end take a self-assessment test, and then receive category one CME credits via E-mail. A future paper in this series will deal with multimedia medical resources that are approximating this goal.



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DELPAC Letter

G. Stephen DeCherney, M.D., M.P.H.

The three Co-Chairs of DELPAC (Drs. Edell, Katz, and Quinn) have it right. Target-seeking crusades and regulators have forced physicians to band together to establish our own agenda. In a recent letter I received from DELPAC, they quote the framers of the Declaration of Independence: "United we stand, divided we fall."

For a long while, I have been willing to accept that HMOs and insurers were interested in improving quality by reducing variation and, hence, waste. Ten years or more into this experiment, I have not seen much evidence of the quality improvement. As the Regional Councilor for the Health Care Division of the American Society for Quality, I am tuned into these issues. There have been genuine, real and sustained quality improvements in the delivery of health

care, but similar improvements long antedated the advent of managed care. Indeed, they were likely to spread from other industries into health care anyway.

Instead, what I have witnessed is needless intrusion into the examining room by outsiders who only want to save money regardless of benefit or harm. For example, Medicare now requires completion of a one page form every six months to justify paying for glucose testing strips. To the best of my knowledge, no one has been cured of diabetes. Consequently, once diagnosed with diabetes mellitus Type 2, patients will have to check their glucose at home for the rest of their lives. Who benefits from completing this form every six months? It is an unnecessary addition to a long day. Every time I have to complete a form while a patient waits, that patient has less time with me. Patient hours are a zero-sum equation. Any time subtracted for patient-specific paperwork comes from that

G. Stephen DeCherney, M.D., M.P.H., is the Editor of the Delaware Medical Journal

patient's office time. As suggested in the DELPAC letter, we need some thoughtful health insurance reform, especially in the form of a patients' bill of rights.

Personally, I would like to re-establish the collegiality of being a physician. I have a sense of isolation in my frustration. As Lilly Tomlin once quipped: "The problem with winning the rat race is that you are still a rat." I think this sense of isolation emanates not from any uniqueness of my practice, but rather that we lack a cohesive agenda collectively. I have had occasion recently to re-read some of the Federalist Papers written by James Madison, Alexander Hamilton, and Thomas Jefferson. They are as revealing for their controversy as for their unity. The founding fathers of the United States were often in heated debate about the right course of action. Only in retrospect have their voices been blended into a symphony from the original cacophony. The Medical Society of Delaware, or DELPAC, offer a similar forum for debate. To their credit, the authors of the United States Constitution were able to put aside their individual feelings and construct a document binding all of them together. As physicians in 1999,

we need a similar willingness to work together and make some individual sacrifices.

Frankly, it is hard to know where to begin. Partially due to the increase in work in practices, physicians are overwhelmed with responsibilities already. Attempting to gather physicians together consistently is difficult. There is the perceived hopelessness of the situation. Each physician thinks that by standing alone he or she will survive somehow. There are known and entrenched constituencies. We seem to be outmanned, out-gunned, and out-financed. In the end, however, we have the only thing that matters: the patient's outcome. Perhaps we should make our stand starting with a list of clinical issues and showing how the current combination of insurance/regulatory/bureaucratic programs deleteriously interferes with helping the patient.

In any case, I am reluctantly converted to the opinion that something has to be done. *When in the Course of human events . . . a decent respect to the opinions of mankind requires that they should declare the causes which impel them.*

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November 9, 1959 - February 26, 1998

and the

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Joseph P. Olekszyk, D.O.

Stuart Burton McMunn was born on November 9, 1959, of Scottish heritage. He was the son of Dr. H. Earl McMunn and the late Dorothy Burton McMunn of New Castle, Pennsylvania.

He attended Penn State University as a pre-med major and also participated on the Nittany Lions football team. During that time, he was captain of the specialty team and shared in the victory of the 1982 National Championship and winner of the 1983 Sugar Bowl.

Stuart continued his education at the Temple University School of Medicine, fulfilling his dream of becoming a physician. While at Sacred Heart Hospital in Allentown, Pennsylvania, Stuart completed his residency program in family medicine.

It was also at Sacred Heart Hospital that he met his future wife, Lisa Brobst, a registered critical care nurse.

They came to Delaware in 1990. Stuart accepted his position in family practice in Georgetown, Delaware, and was affiliated with Nanticoke Memorial Hospital.

Trevor Allan McMunn was born on January 26, 1993; Kelsey Elizabeth followed two years later on March 25, 1995.

Stuart shared a lifelong love of sailing with Lisa on an island hopping cruise of the Caribbean.

Joseph P. Olekszyk, D.O., is an Otolaryngologist practicing in Seaford, Delaware.

Later, he enjoyed a similar sailing excursion with his father ... back to the Caribbean for one final time.

Stuart B. McMunn was a man of faith, integrity, and honor. His love for God, family, friends, and community gave purpose to his life. His courage and faith have touched all who knew him.

McMunn Educational Trust

The McMunn Educational Trust is an education trust established by members of the medical staff of Nanticoke Memorial Hospital. It is for the sole purpose of providing funding for post-secondary education and college for Kelsey and Trevor McMunn, children of Lisa McMunn and the late Stuart McMunn, M.D.

Stuart McMunn was a dedicated and compassionate physician, respected colleague and young leader of the Nanticoke Memorial Hospital Medical Staff. His untimely death at the age of 38 years occurred after a brief but terrible illness.

The educational trust is independently administered by Mellon Bank, Delaware. The cost and expense of their trust are generously borne by Mellon Bank, Delaware. All funds received are utilized for the trust beneficiaries. Donations may be sent directly to the trust at the following address:

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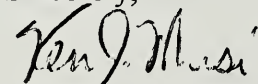
To: Medical Professional
From: Ken J. Musi
Re: Health Care Real Estate in Delaware

Within the field of medicine, physicians specialize in order to best meet the medical needs of their patients. As a commercial real estate agent, I have done likewise for equally important reasons. By becoming an expert in the field of real estate specifically suited for the Health Care industry, I have helped hundreds of physicians and medical groups acquire, sell or lease space appropriate for medical practices and health related facilities.

Since beginning my career in 1989, I have built a client base that has come to value the knowledge and expertise that I have acquired through this specialization in real estate. Many Physicians, Residential real estate agents, attorneys, accountants, and other Commercial real estate agents also recognize the importance of such a specialty, with much of my business resulting in referrals from this important professional network. Some of my clients have included: Blue Cross Blue Shield of Delaware, the duPont Hospital for Children, St Francis Hospital (Franciscan Family Care), Riverside Hospital, Christiana Care, First State Orthopaedics, The Delaware Heart Group, Gastroenterology Associates and many more. In addition, I have also assisted many physicians in finding suitable sites to develop an office building either for their business or for the purpose of investment. Whether assisting physicians just completing residency, or business managers of large practices, my real estate expertise in the Health Care field can be of tremendous value. As a member of the DMGA (Delaware Medical Group Managers Association), I remain involved in the concerns and issues facing the medical community providing an extended benefit to all of my clients.

Should you have a building suitable for Health Care use, please call me if you plan to sell or lease. Within my database may be someone needing exactly what you have. If you are looking for space to start a practice, move a practice, or add additional locations, check with me first as I will probably be aware of a building or location perfect for your needs. My goal is to provide the highest quality of service while offering you the greatest level of expertise as it relates to your real estate needs in leasing, buying or selling property in the specific area of Health Care. I look forward to hearing from you.

Sincerely,



Ken J. Musi



Radical or Conservative?

E. Wayne Martz, M.D.

It was the early 1970s, and the conference was discussing a woman in her mid thirties with rheumatic mitral valvular disease who had recently had a cerebral embolus, presumably from an atrial mural thrombus. Argument raged over whether to try conservative treatment with anticoagulants, or to send her to Philadelphia for radical open heart surgery. As I listened, it became apparent to me that what was being called radical might be safest for the patient and thus most conservative, whereas the traditional anticoagulants might carry the greatest risk and in that way be the most radical.

Similar upside-down reasoning can be applied to a great many medical-surgical problems. Do you send your ulcerative colitis patients for colectomy and ileostomy once they are stabilized, to avoid the unacceptably high risk of carcinoma? For a clean pneumothorax, is a chest tube radi-

cal or conservative? Often it is not clear which course is safest and best in the long run.

Too often prejudice, ignorance and other factors enter into the decision. I have heard it said (partly in jest) by enthusiastic, academic medical residents, that the primary duty of every good internist is to keep the patient out of the hands of the surgeon; this by doctors who have never set foot in an O.R. since their student days, and even then, they didn't have gloves on or belly up to the table. At the same time, the surgical residents tend to try to cure every case surgically when there are perfectly safe and effective medical measures available, and they complain that they are always called in too late and are expected to pull the medical chestnuts out of the fire by last ditch heroics. Worst of all are the pediatricians whose world is divided into pediatricians and non-pediatricians, the latter hardly worthy of the M.D./D.O. degree. Much of this misunderstanding goes back to the demise of the rotating internship 50 years ago, which

E. Wayne Martz, M.D., is the Editor Emeritus of the Delaware Medical Journal.

was itself a power play to preempt the best graduates into one's own specialty. If we work together, we come to understand each other, and the patients benefit. In recent years, some of this estrangement may be ameliorated by residencies like Family Medicine and Emergency Medicine and certain two specialty combinations, which make us realize that there are several valid approaches to every question. In backing away from one problem, we may be backing into others far worse.

In our zeal to empty institutions for the retarded, we created armies of people in the streets who are mentally challenged even before smoking their first joint. If they have no visible father, or their father was himself similarly liberated, there is no guidance. They are easily led into crime, drugs, violence, teen pregnancies, homelessness. In our efforts to be fair and compassionate, and mainstream low IQ children, we have diluted the educational opportunities for our more talented youngsters. Large portions of our school budgets go to guarantee education for those who have no interest in it or lack the ability to profit from it. In our compas-

sion and desire to assure sustenance for all children, we guarantee every teenage girl who thinks it might be fun to have a baby that she won't have to worry about supporting it. The government will provide the finances and other support for her to do so virtually without any penalty. In fact, she gains a certain status and distinction in the eyes of her peers. When the era of the psychopharmaceuticals arrived with Thorazine in 1953, we emptied out our mental hospitals, and now wonder at the rising incidence of bombs and crazies of every description disrupting society.

There was a saying prevalent in our hospitals a few years ago which may still be relevant. Compassion and love of humanity is fine, but there is nothing so inhumane as incompetence. I would add that it is easy to be so blinded by a single minded humane purpose that we overlook the need to think through the unintended consequences of our actions. It is often not easy to tell radical from conservative — to tell which course of action is the safest, the most compassionate and the most likely to lead to a better society in a better world.

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DATE: May 4-6, 1999
WHERE: The Delaware Academy of Medicine
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Sponsored by the Medical Society of Delaware, Christiana Care Health Services, and the Delaware Academy of Medicine.

For more information, contact William J. Holloway, M.D., Director of Infectious Diseases, Christiana Care Health Services: 302-428-2744.

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Where: Arsht Hall, Wilmington Campus
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For more information or an invitation, please contact Emily Knearl at 577-8153. There is a registration fee of \$25.

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Abcess Localization

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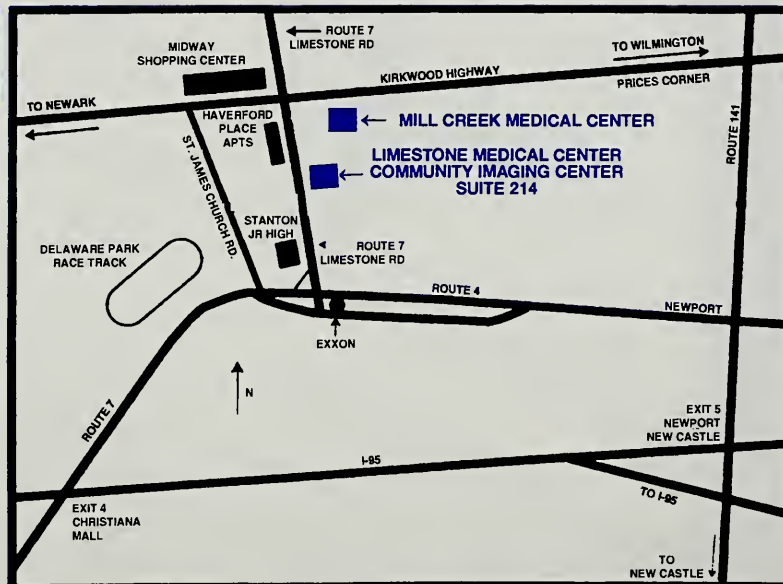
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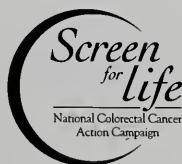
She shared why she got a screening test for colorectal cancer.

When Helen talked to me about colorectal cancer, I listened—and learned. Her doctor said that colorectal cancer (cancer of the colon or rectum) is the second-leading cancer killer. And that the risk increases as you age, especially after 50. Screening tests are often the only way to detect the disease in the early stages—when there may not be any symptoms and when treatment can be most effective. Everyone, both men and women, 50 and older should get colorectal cancer screening tests. So that's exactly what I'm doing. Thanks to Helen!

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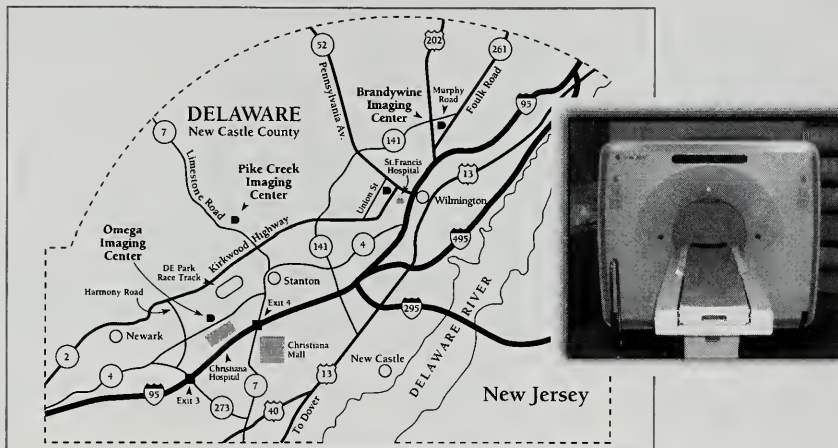
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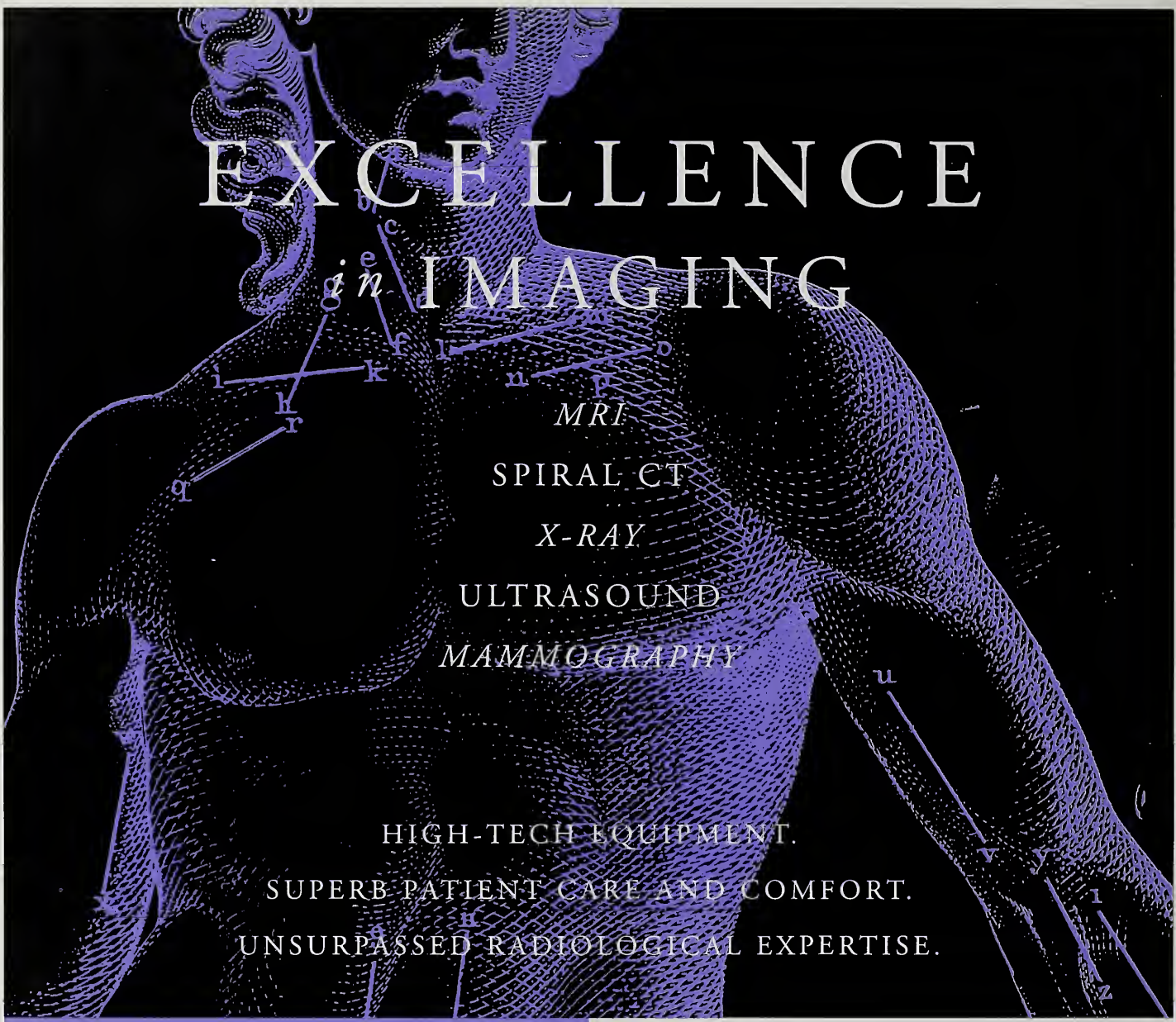
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"Health Illiteracy" A Serious and Growing Problem

Martin G. Begley, M.D.



It is generally assumed that offering patients written instructions is a sure way to give them what they need to know about their medication, activity levels and other information necessary for their recovery. So it was not surprising that a group of physicians, nurses and other health care givers and medical administrators were astonished watching a video at the AMA Media and Communications Conference that proved otherwise.

Appearing on the screen were well dressed, intelligent-appearing and articulate men and women who confessed, sometimes tearfully, that they were illiterate. Many spoke with such a healthy vocabulary it seemed impossible that they could read only at the second or third grade

level. These are not isolated cases; there are millions more. Our nation was once first in literacy but now is only twenty-ninth; there are 40 million functionally illiterate Americans out there! This presents a serious problem for society in general and a more serious one for physicians because while millions have weak skills in general reading many of these are overwhelmed with the simplest medical language. These individuals can't read medication labels or their physician's instructions, and they can't understand a consent form, news articles on medicine or insurance forms — they suffer from "health illiteracy." In public hospitals, up to 40 percent of English speaking and 55 percent of Spanish speaking patients are health illiterate. The incidence of this form of illiteracy increases with age and it is estimated that across all socioeconomic classes, 15 percent of those aged 65 to 69 years and 58 percent of those 85 years and older are health illiterate.¹

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, DE. He is the president of the Medical Society of Delaware.

This problem causes tremendous cost to both the individual and society. Those who read at the lowest levels (grades zero - two) have average annual health care costs of \$12,974 as compared with \$2,969 for the overall population. The total bill for health illiteracy is believed to be \$73 billion.

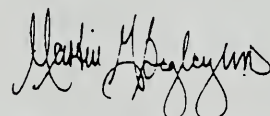
The problem and its attendant cost are expected to grow quickly in the future because of our rapidly aging population and the development of more complex therapies. Increasingly, patients need to be knowledgeable and understanding partners with their physicians now more than ever before. For example, 25 years ago, asthma was treated with theophylline and little else. Now patients are also expected to use peak flow meters, select and correctly use inhalers, occasionally augment therapy with tapering steroid doses, etc.² To successfully follow such regimens, patients need solid reading and computational skills. Therapeutic regimens for other diseases are also more involved than they once were and, consequently, demands for health literacy are increasing.

So it is extremely difficult to care for health illiterate patients. Not being able to follow written directions, good treatments offered them fail and complications ensue. Often they seem refractive to prescribed medications and may be switched to others that may be unnecessarily more expensive when in fact they never took the original prescription correctly, if at all. Others may be written off as non-compliant. Still others may do themselves serious harm and, in such situations, the physician may become the scapegoat in a malpractice action.

Compounding the problem is that these people are hard to identify. They have a deep sense of shame about their handicap and likely won't

reveal it to their physician or others. Ninety percent hide it from their children, 60 percent haven't told their spouse and 29 percent have never confided it to anyone else.

What can physicians do about health illiteracy? First, we have to recognize the existence of this problem that has only recently been identified and still needs study to be fully quantified and to find solutions. Gently assessing patients' ability to read the instructions on their prescriptions is a simple way to get some idea of their health literacy. The AMA is developing a short test that could be done as part of the initial physical examination to assess a patient's health literacy; it should be available to physicians in the near future. We must also be mindful that illiteracy is one of the possible causes for a patient's noncompliance or failure to respond to therapy. Finally, it is essential that we have a sense of compassion for those afflicted with this handicap. Maybe then they will find comfort being honest with us so we can best care for them.



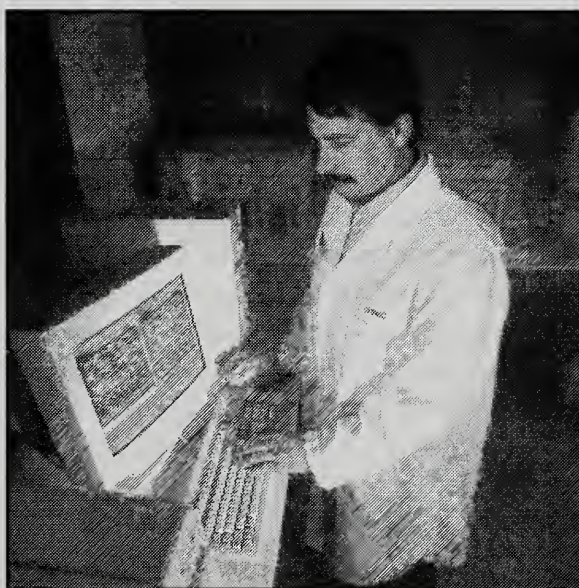
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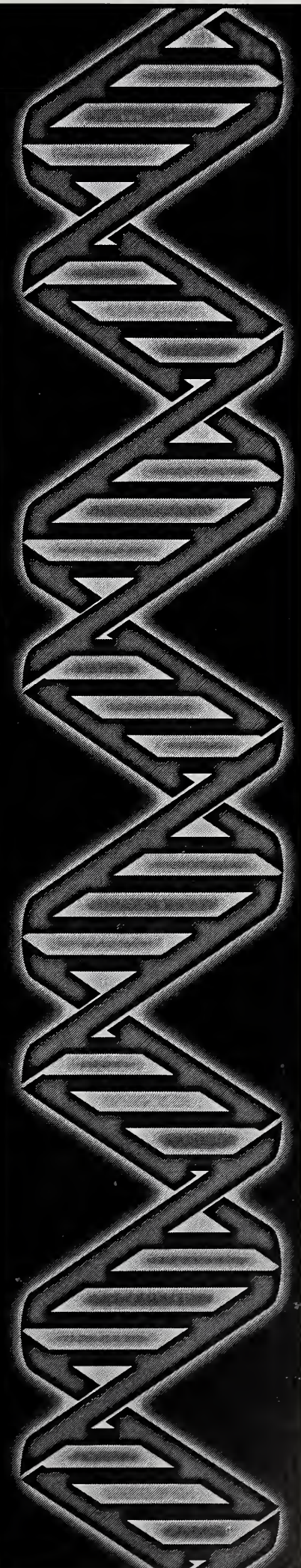
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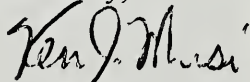
To: Medical Professional
From: Ken J. Musi
Re: Health Care Real Estate in Delaware

Within the field of medicine, physicians specialize in order to best meet the medical needs of their patients. As a commercial real estate agent, I have done likewise for equally important reasons. By becoming an expert in the field of real estate specifically suited for the Health Care industry, I have helped hundreds of physicians and medical groups acquire, sell or lease space appropriate for medical practices and health related facilities.

Since beginning my career in 1989, I have built a client base that has come to value the knowledge and expertise that I have acquired through this specialization in real estate. Many Physicians, Residential real estate agents, attorneys, accountants, and other Commercial real estate agents also recognize the importance of such a specialty, with much of my business resulting in referrals from this important professional network. Some of my clients have included: Blue Cross Blue Shield of Delaware, the duPont Hospital for Children, St Francis Hospital (Franciscan Family Care), Riverside Hospital, Christiana Care, First State Orthopaedics, The Delaware Heart Group, Gastroenterology Associates and many more. In addition, I have also assisted many physicians in finding suitable sites to develop an office building either for their business or for the purpose of investment. Whether assisting physicians just completing residency, or business managers of large practices, my real estate expertise in the Health Care field can be of tremendous value. As a member of the DMGA (Delaware Medical Group Managers Association), I remain involved in the concerns and issues facing the medical community providing an extended benefit to all of my clients.

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Sincerely,



Ken J. Musi



Success in Using Non-Invasive Mechanical Ventilation Is Predicted by Patient Pathophysiology A Retrospective Review of 199 Patients

Scott P. Krall, M.D.¹ — Marc T. Zubrow, M.D.² — Michael E. Silverman, M.D.¹

Key Words: Mechanical Ventilation, Respiratory Failure, Acute Respiratory Distress Syndrome, Chronic Obstructive Pulmonary Disease, Sepsis, Congestive Heart Failure

Abbreviations: rapidly reversible disease processes (RRDP), non rapidly reversible disease processes (NRRP), non-invasive mechanical ventilation (NIMV), continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP), arterial blood gas (ABG), cardiogenic pulmonary edema (CPE), chronic obstructive pulmonary disease (COPD), acute myocardial infarct (AMI), acute respiratory distress syndrome (ARDS)

Background: To determine the effect of patient pathophysiology on the success or failure of noninvasive mechanical ventilation as determined by the need for subsequent endotracheal intubation.

Methods: Center-based, retrospective case analysis of all patients placed on non-invasive mechanical ventilation for acute respiratory distress

Measurements and Results: Retrospective chart review was performed on patients who were treated with non-invasive mechanical ventilation from 1/94-6/97. Patients were divided into those with rapidly reversible disease processes

(RRDP), and those with non rapidly reversible disease processes (NRRP). The proportion of patients requiring subsequent intubation in each group was compared. There were 116 patients with RRDP and 83 patients with NRRD. In the RRDP group, 85.8 percent (95 percent confidence interval 80.9-90.7 percent) of patients did not require intubation. In the NRRP group, 35.7 percent (95 percent C.I. 29.0-42.4 percent) did not require intubation (X² analysis, $p < .001$). Multivariate analysis identified patient pathophysiology as the only variable associated with subsequent intubation.

Conclusions: Patient pathophysiology, based upon their expected clinical course can be used to predict the success of non-invasive mechanical ventilation (NIMV). Patients with NRRD, such as pneumonia, myocardial infarct and sepsis, are much more likely to fail non-invasive mechanical ventilation and require subsequent endotracheal intubation.

1. Emergency Medicine Department - Christiana Care Health Services - Newark, Delaware

2. Pulmonary Disease and Critical Care Medicine - Wilmington and Newark, Delaware.

This paper was presented on November 25, 1996, in San Francisco at the American College of Chest Physicians.

INTRODUCTION

Patients with respiratory distress account for a large proportion of total hospital morbidity and mortality, and frequently require intubation. Over the past decade continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP) have been increasingly used to support these patients. The efficacy of CPAP and BiPAP has been studied in different patient populations with respiratory distress.^{1,2,3,4,5,6,7,8,9,10,11,12,13,14} NIMV has permitted the avoidance of many of the complications of intubation including the short term complications of pneumothorax and unrecognized esophageal intubation and the long term complications of nosocomial pneumonia, laryngeal mucosal ulceration and tracheal stenosis.¹⁵ NIMV also eliminates the risk of prolonged initial intubation time, thus avoiding the associated anoxia,¹⁵ allowing the patient to maintain the ability to speak, and eliminating the discomfort of the endotracheal tube.⁹

We have used NIMV for a variety of patients to avoid the risks of intubation. It was our impression that patients with more serious disorders, i.e. those who seemed to have less medically reversible pathophysiologic abnormalities, were more likely to ultimately require intubation.

We were concerned that this subgroup of patients with respiratory distress might not benefit from NIMV even as an initial trial.

MATERIALS AND METHODS

The study is a retrospective review of all patients placed upon NIMV for respiratory failure as determined by the treating physician, either BiPAP or CPAP from January 1, 1994, to June 31, 1997, at the Medical Center of Delaware (now Christiana Care Health Services), two non-profit teaching hospitals with 1090 beds total. Patients requesting no intubation, trauma patients, and post-operative patients were excluded from the study. The protocol was reviewed by the institutional review board and approved.

The study population was divided into two groups based on patient pathophysiology. Patients with a RRDP included those with congestive heart failure, status asthmaticus, and exacerbation of chronic obstructive pulmonary disease or bronchitis. RRDP were those with underlying disease pathology that can be reversed in a short period of time by our present medical therapies. Criteria of inclusion were: congestive heart failure (chest radiograph with vascular congestion and improvement in chest

Table 1. Demographic data, mortality, and initial vital signs. All data are compared between successful noninvasive mechanical ventilation and intubation. Parentheses indicate percentages.

	<i>All Patients</i>		<i>Successful NIMV</i>		<i>Intubated</i>		p-value
	Mean	Median	Mean	Median	Mean	Median	
Sex: Female (%)	111 (55)		81 (73)		30 (27)		p=.039
Location NIMV Started ER (%)	119 (60)		90 (76)		29 (24)		p<.001
Hospital Mortality (%)	199 (13.3)		2 (2)		25 (36)		p<.001
Intubation (%)	71 (34.8)		0 (0)		71 (100)		
Age	66.4	69	68	70	63.3	67	p=.009
Initial Pulse	114.8	112	116	113.3	112.2	110	p=.307
Initial Systolic BP	142.5	147.6	156	154	129.3	130	p<.0001
Initial Respiratory Rate	30	30	29.5	28	31.3	32	p=.216

Table 2. Disease Process (Reversible versus Non-reversible), Specific Diagnoses: Frequency of Diagnosis and Intubation Intubation

<i>Disease</i>	<i>Frequency dx n (%)</i>	<i>Intubation Rate</i>
<i>Reversible:</i>	116 (59)	15 (13)
Intubated Prior 2nd ABG		6 (35)
CHF	64 (30)	7 (11.3)
Asthma	9 (4.6)	1 (11.2)
Bronchitis	43 (20)	7 (16.7)
<i>Non-reversible:</i>	83 (41)	55 (64)
Intubated Prior 2nd ABG		20 (37)
ARDS	9 (4.4)	9 (100)
AMI	36 (18)	19 (43)
Pneumonia	27 (14)	19 (71.4)
Sepsis	11 (5.6)	8 (75)
<i>Other</i>	5 (2)	2 (40)

radiograph over the next 48 hours), status asthmaticus (history of asthma and wheezing on exam), bronchitis (wheezing and history of chronic obstructive disease without acute chest radiograph changes). Patients with a NRRP are patients with disease pathology where one would anticipate a longer course despite modern medical intervention secondary to underlying organ damage. NRRP included pneumonia, sepsis, acute respiratory distress syndrome, and acute myocardial infarct. Criteria of inclusion were defined as: pneumonia (new infiltrate on chest radiograph), sepsis (appropriate clinical presentation and infectious source), adult respiratory distress syndrome (increased alveolar-arterial gradient, multiple areas of alveolar infiltrate on chest radiograph, and decreased compliance), acute myocardial infarct (creatinine kinase MB elevation during the initial 24 hours of hospitalization).

Intubation was determined by the treating physician. In general, patients were intubated based upon worsening clinical condition. Some patients had progressive acidosis or hypoxia prior to intubation, but not all patients had laboratory documented indications for intubation.

The primary ventilators used for NIMV included: Respironics Inc. BiPAP S/T-D for bilevel

positive airway pressure support, and Vital Signs Variable Resistors with high flow blender for continuous positive airway pressure. The type of mask was a full face mask with both machines. Invasive mechanical ventilation, when used, varied depending on the machine available.

The following data were collected: age, gender, initial pulse, initial respiratory rate, initial blood pressure, time of initial arterial blood gas (ABG), location in the hospital of initiation of NIMV, time of initiation NIMV, duration of NIMV in minutes, subsequent ABG while on NIMV, primary acute diagnosis, secondary acute diagnosis, chronic diagnosis, chest roentgenogram interpretation, creatine phos-

phokinase level including myocardial isoenzyme level, intubation, and hospital mortality. Chest roentgenogram interpretation was done by both a radiologist and an investigator; if there was a dispute based upon comparison of prior and subsequent roentgenogram, a third reviewer blindly evaluated the roentgenogram.

The data were analyzed using the statistical applications JMP (version 3.6, SAS Institute, Cary, NC) and CART¹⁶ (Salford Systems, San Diego, CA). The effects of the independent variables on the presence or absence of required intubation were examined individually with the Chi-square test and by student T test. Multivariate analysis using CART was performed by construction of classification trees, a non-parametric method that finds the optimum combination and order of independent variables to separate the patients into groups based on the dependent variable, whether the patient required subsequent intubation. The analysis involved 15 independent variables including: age, sex, location, systolic blood pressure, pulse, respiratory rate, type disease process (reversible versus non-reversible, as defined in the methods section), pCO₂, pH, second pH, second pCO₂, change in pH, and change in pCO₂. Summary statistics were used for data presentation in the tables with student T test for comparison of intubated patients versus successful NIMV.

Table 3. Initial and Repeat Laboratory Evaluation (when done within two hours initiation NIMV), Entire Patient Population, and Specifically for Congestive Heart Failure and COPD Patients .

Variable	Study Group		NIMV		Intubated		p value
	Mean	Median	Mean	Median	Mean	Median	
pH ABG1	7.28	7.29	7.3	7.3	7.3	7.31	p=.235
pCO2 ABG1	62.3	56.4	63.5	60.5	60.3	47.2	p=.433
NIMV till ABG2 (Time:minutes)	324	71	178.5	65	516.7	100	
pH ABG2*	7.33	7.33	7.3	7.3	7.3	7.3	p=.528
pH change*	.048	.04	.06	.05	.02	.03	p=.021
pCO2 ABG2*	57.9	52	57.6	53.3	72.5	76.7	p=.309
pCO2 change*	7.65	6	10.1	8.2	.77	3.1	p=.0077
CHF Patients Only							
pH ABG1	7.3	7.3	7.3	7.3	7.3	7.3	p=.7778
pCO2 ABG1	62.4	56.4	59.3	55.1	62	48.4	p=.6479
NIMV till ABG2 (Time: Minutes)	277	73	165	69	453	157.5	p=.018
pH ABG2*	7.3	7.3	7.3	7.3	7.3	7.2	p=.3237
pH change*	0.07	0.06	0.08	0.07	0.03	0.03	p=0.1008
pCO2 ABG2*	55.7	51.4	54.6	51.4	67.5	60	p=.2272
pCO2 change*	11.4	9.4	11.8	9.35	7.0	8.5	p=0.41
COPD Only							
pH ABG1	7.3	7.3	7.29	7.31	7.26	7.25	p=.703
pCO2 ABG1	79	76.3	76.4	76	86.2	76.25	p=0.108
NIMV till ABG2 (Time: Minutes)	464	68	216	68	1356	72.5	p=0.280
pH ABG2*	7.3	7.3	7.3	7.3	7.3	7.2	p=0.5310
pH change*	.03	.03	.027	.03	.026	.02	p=.0022
pCO2 ABG2*	72.2	72.15	69.4	70.7	81	81	p=.3102
pCO2 change*	5.2	4	8.09	7	-3	-3.5	p<0.0001
*All Values done within 120 minutes of initiation of NIMV							

RESULTS

There were 199 patients consisting of 88 men and 111 women, ranging in age from 16 to 94

years with a median age of 69 years. Patient age, sex, location in the hospital, heart rate, systolic blood pressure, respiratory rate are presented in Table 1. Table 2 presents the disease categories with the intubation rates. Blood gas values, changes in blood gas and time on NIMV for the entire study group, for the CPE patients and the COPD patients are presented in Table 3.

The data were analyzed using a CART program¹⁶ (Salford Systems, San Diego, California, U.S.A.). The conclusion was that disease process provided the best predictor of intubation. This conclusion was also supported by the chi2 analysis done with intubation versus disease process, $p<.0001$. The other variables were analyzed individually by chi2

whole model test and presented in Table 3. The only significant p values were in location, age, systolic blood pressure, and change in pH and pCO2. The change in pH and pCO2 represent a

possible method of predicting success with improvement in the subsequent ABG values.

Analysis of all patients with cardiogenic pulmonary edema (CPE) (Table 3), showed that initial ABG values were not significantly different. The similarity in the initial ABG results support matched patient populations physiologically. Repeat ABG values showed a possible trend toward improvement in both pH and pCO₂, but the CPE intubated group with a second ABG within 120 minutes included only four patients.

Analysis of patients with acute chronic obstructive pulmonary disease (COPD) bronchitis or COPD complicated by pneumonia shows pneumonia as predictive of failure and subsequent intubation. Initial presentation and laboratory analysis are shown in Table 3. Analysis of initial pH and pCO₂ shows no significant difference in initial ABG values, again supporting both patient populations being physiologically matched. The second ABG values were significantly improved but again represent only a very small number of patients, with only eight patients in the intubation group.

DISCUSSION

Our data show that a patient's pathophysiologic cause for respiratory failure is predictive of successful NIMV. Therefore, the underlying disease process should be taken into account in the care of a patient being considered for NIMV. The RRDP group had the following intubation rates: 11.3 percent for CHF without acute myocardial infarct (AMI), 11.2 percent for asthma, and 16.7 percent for bronchitis/COPD. This supports NIMV use in these patients to avoid the potential complications of intubation. The NRDP group had the following intubation rates: 43 percent for AMI, 75 percent for sepsis, 71.4 percent for pneumonia, and 100 percent for acute respiratory distress syndrome (ARDS.) These rates indicate increased risk of a poor outcome with little benefit of NIMV when used in these patients. We postulate the increased work of breathing secondary to decreased lung compliance and respiratory muscle dysfunction cannot be supported adequately by NIMV for the extended period required for resolution of the underlying disease process in the NRDP group.

Though the study is retrospective with multiple physicians determining the need for NIMV, type of NIMV as well as evaluating the need for intubation, and the decision to use NIMV and intubate was frequently made based on clinical impression alone. The above factors as well as the nature of RRDP can lead to a bias of increased success in this group when patients without severe distress are placed on NIMV. The subsequent high intubation rate in the NRDP group remains significant in our opinion despite the potential earlier biases. Reviewing Brochard's 1995¹ *New England Journal* study of success in use with COPD patients excluded septic patients, acute myocardial infarct, and severe pneumonia patients, the study by Bersten 1991¹⁷ *New England Journal* on use with cardiogenic pulmonary edema excluded myocardial infarcts with shock, the study had seven myocardial infarcts with two intubated. The above studies are used to confirm NIMV as a method of supporting patients in respiratory distress but in general excluded the patients we were unsuccessful in using NIMV.

Patients with cardiogenic pulmonary edema (CPE) have been shown to benefit from NIMV in the past. Our entire CPE group including both acute myocardial infarct patients with complicating CPE and isolated CPE intubation rate was 23 percent overall. This rate was similar to those described by Pennock in 1991¹⁰ and 1994¹² with rates of 24 percent and 20 percent respectively, as well as Bersten in 1991¹⁷ with a rate of 0 percent. Lin et al⁷ studied 100 patients with CPE and found a significant reduction in the need for intubation when NIMV was utilized. Intubation was required in eight of 50 patients in the NIMV group as compared to 18 of 50 patients in the control group. Sacchetti et al⁸ found a trial of NIMV avoided intubation in 20 of 22 patients in whom endotracheal intubation appeared warranted. Teba et al⁹ demonstrated a response to BiPAP in 21 of 27 patients. The initial ABG values including pH and pCO₂ are not predictive of success of NIMV in these patients. This is consistent with past studies by Pennock¹² and Brochard.¹ Our study, as well as those by Meduri¹¹ and Bernsten,¹⁷ found a trend toward significance when an ABG taken within 120 minutes of the start of NIMV predicted

success. Patients in our study with CPE, but no complicating myocardial infarct, as their presenting disease process did not seem to vary from the entire study population except for more rapid improvement in pH and pCO₂, similar to the study by Bersten et al.¹⁷ The data presented show a trend, but it involves a small number of patients, and the study was not designed to determine a predictive test for intubation, so the results should not be used for determining intubation but as part of the information used for patient management. When proposing NIMV in AMI, consideration should be given to the increased intubation rates as well as the increased cardiac demand without intubation. This information, in combination with a NRDP such as AMI, should prompt earlier intubation if little or no improvement is seen.

NIMV has been shown to reduce the need for endotracheal intubation in patients with COPD. Brocard et al demonstrated NIMV decreased the need for endotracheal intubation in selected patients with COPD exacerbation as compared with standard treatment (oxygen by nasal prongs up to 5 liters). Our intubation rate of 20 percent was similar to those rates reported in the literature (26 percent for Brochard et al¹ and 18 percent for Meduri in 1996¹¹). In a small study by de Lucas et al,² use of nasal CPAP produced a decrease in respiratory rate, sensation of dyspnea, and an increase in PaO₂ in 15 patients with COPD exacerbation. Miro et al⁴ showed similar results utilizing mask CPAP such that five of seven patients had significant improvement in gas exchange. Kramer et al⁵ found in a subgroup of COPD patients with respiratory distress, eight of 12 control patients required intubation compared with one of 11 NIMV patients. These small studies of COPD patients demonstrate a marked benefit from the use of NIMV in order to avoid intubation. Similar to a presentation at Society of Critical Care (2/6/97-2/10/97), our patients with COPD and a complicating additional acute pulmonary process, such as pneumonia, are subsequently intubated. In contrast to the CHF group, this group may have a prolonged course prior to failure of NIMV. This makes them more labor intensive and requires close monitoring for an extended time period if one is attempting NIMV.

Mortality was not analyzed extensively; it is presented, but as anticipated, it is higher in the intubated group. It is also higher in the non-rapidly reversible group: 27 percent versus 2.5 percent. The deaths in the reversible group occurred after successful ventilation and several days off NIMV. The significance of this cannot be determined without a more extensive prospective study. However, in the NIMV group with non-reversible disease processes early in the study period we had four cardiac arrests resulting in intubation and subsequent death. This trend did not continue but does give some concern about the use of this modality in certain populations. The arrest patients ranged from one hour after initiation of NIMV to 14 hours with two myocardial infarcts in the group, a pneumonia, and a gangrene (sepsis) patient. It is difficult to draw any conclusion from this data other than people placed on NIMV for respiratory distress need very close monitoring.

NIMV is an excellent modality for the treatment of acute respiratory failure in those patients whose disease processes can be rapidly reversed with appropriate intervention. We recommend that all patients on NIMV for respiratory distress be very closely monitored, with early intubation should the patient not improve in a reasonable period of time based on their disease process. Patients with CPE pathophysiologically have decreased cardiac output resulting in increased pulmonary end diastolic pressures; therefore, by decreasing end diastolic pressure, respiratory failure can be rapidly reversed. Baratz showed increased cardiac output in a population of patients on CPAP. This increase was secondary to an increased stroke volume and not a decreased pulmonary capillary wedge pressure.¹⁸ The present therapies for treating CPE can reduce increased end diastolic pressure quickly, producing improvement in a few hours, during which time CPAP provides patient assistance. By contrast, COPD with bronchitis has inflammatory bronchospasm as the underlying pathophysiology and requires reversal of the bronchospasm as well as suppression of the inflammatory process. Treatment may require days to have a lasting impact on the underlying process. Our retrospective data show that the COPD bronchitis patients required a longer

trial before intubation. Uncomplicated CPE, asthma and COPD bronchitis are rapidly reversible disease processes and are good candidates for a trial of NIMV. The NRDP group, including sepsis, ARDS, and pneumonia, may occasionally respond to NIMV, but one needs to keep in mind expected time courses and intense monitoring to avoid unnecessary increased morbidity and mortality.

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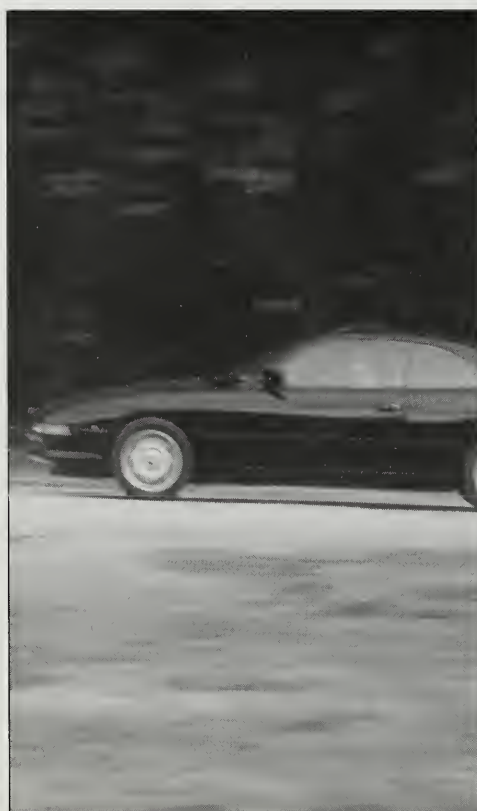
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Spiral CT and Pulmonary Embolism: Is the Emperor Still Unclothed?

James F. Lally, M.D. — Mark D. Jones, M.D.

Eugene Robin's provocative 1977 article, "Overdiagnosis and overtreatment of pulmonary embolism: the emperor may have no clothes," stirred the medical profession to rethink its strategies in the diagnosis and treatment of pulmonary embolism (PE).¹ In the decade that followed, ventilation-perfusion scintigraphy (V-P) and pulmonary arteriography continued to remain the mainstay of diagnosis. Yet, there was often considerable doubt and confusion about their accuracy and utility in the diagnosis of pulmonary embolism. When one considers that deep venous thrombosis and subsequent pulmonary emboli result in over 300,000 hospitalizations and an estimated 50,000 deaths per year in the United States, there was unquestionably a

pressing need for further clinical research and, more importantly, clearly defined guidelines that would result in improvement in the clinical management of patients with this life-threatening disorder.

In the mid to late 1980s, it was realized that what was urgently needed were reliable data and a sensible algorithm as well as robust noninvasive imaging techniques for the diagnosis of PE; this would give clinicians the confidence that they would neither be undertreating or overtreating PE. While no imaging strategy can be molded to fit the patient who presents with multiple, complex variables, it was thought that a well-reasoned outline of imaging decisions would be better than relying on clinical guesses and anecdotal experience.

The long-awaited results of the Prospective Investigation of Pulmonary Embolism Diagnosis (PIOPED) study answered part of the problem.²

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This study was a large multi-institutional effort to determine the sensitivity and specificity of V-P scanning for pulmonary embolism compared to the "gold standard" of pulmonary arteriography. The PIOPED study also confirmed the value of combining the pretest clinical likelihood of pulmonary embolism with scan results.

The negative predictive value of a low probability V-P scan when accompanied by a low clinical likelihood of pulmonary embolism was found to be 96 percent. Conversely, the positive predictive value of a high probability scan increased to 96 percent if supported by a high clinical likelihood of PE. Unfortunately, only a minority of patients fell into these two categories, leaving the majority of patients in a less certain (indeterminate) category. In the algorithmic approaches to pulmonary embolism developed since the PIOPED study, patients with an indeterminate V-P scan are subjected to noninvasive studies of the lower extremities; preferably Duplex ultrasonography. Although greater than 90 percent of pulmonary emboli originate in the lower extremities, 40 percent of patients with pulmonary embolism have normal lower extremity studies.

Since peripheral venous thrombosis and PE can be viewed as poles of the spectrum of thromboembolism, efforts must focus on imaging both of these disorders. Hull's protocol provided the impetus for aggressive noninvasive imaging of the leg veins. In patients with indeterminate lung scans and normal lower extremity studies, Hull et al demonstrated that serial noninvasive studies of the lower extremities repeated four times over the first two weeks of follow-up in patients with "adequate cardiopulmonary reserve" was a treatment option.³ Of 627 patients studied whose serial noninvasive studies of the extremities remained negative, only 1.9 percent had documented symptomatic venous thromboembolism within three months of follow-up.

Although pulmonary angiography remains the definitive test in this group of patients, many investigators believe that it has been underutilized in the diagnosis of pulmonary embolism. The drawbacks to pulmonary arteri-

ography include the invasive nature of the test, a fatality rate of 0.5 percent and a significant complication rate of 1.5 percent. What is needed is a noninvasive test that bridges the imaging gap between lung scanning and pulmonary arteriography.

The early 1990s saw a leap forward in CT scanning with the development of the ingenious technique of spiral (helical) CT scanning. In spiral CT, the continuous movement of a patient on a scanning table through an X-ray beam generates a spiral about the body part of interest that allows for the rapid acquisition of a volume of data in a single breath hold. This technique, when combined with the rapid injection of a bolus of intravenous contrast medium, allows for the direct visualization of pulmonary artery clots.

Pooled data on the results of contrast enhanced spiral CT for pulmonary embolism involving central arteries (main pulmonary artery through segmental branches) show an outstanding sensitivity of 94 percent with specificity of 94 percent.⁴ The segmental arteries are problematic; the sensitivity is very low at 13 percent. The prevalence of pulmonary embolism involving only subsegmental pulmonary arteries is six to 30 percent.⁵ Therefore, a normal contrast enhanced spiral CT scan does not exclude pulmonary embolism, particularly in subsegmental arteries. In patients with marginal renal function who may need a subsequent pulmonary arteriogram, it may be best to proceed to pulmonary angiography.

What is the role of spiral CT in patients who present with the clinical suspicion of a pulmonary embolus? While the ultimate place of spiral CT in the diagnostic algorithm for PE is still unclear, it may prove to be most valuable in those patients with a high pretest likelihood of an indeterminate V-P scan; this primarily includes those patients with significant underlying lung disease or an abnormal chest radiograph. In this setting, spiral CT would have a high sensitivity and specificity for proximal pulmonary emboli. Of equal importance, it may disclose an alternative diagnosis, such as opac-

ity, mass, or pleural fluid, in a patient with an abnormal chest radiograph. It should be understood that some of these patients may subsequently require pulmonary arteriography for a nondiagnostic spiral CT of the thorax.

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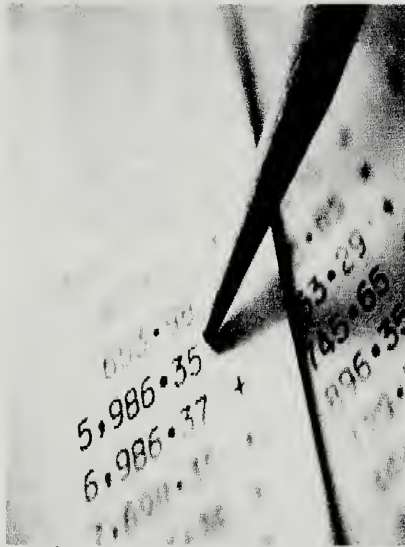
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1998 Laboratory Satisfaction Survey
Conducted by the Medical Society of Delaware

INTRODUCTION

The Medical Society of Delaware (MSD) conducted a survey in November of 1998 to determine the impact of the many changes that have taken place in the delivery of laboratory services in our state. The purpose of the survey was not to reflect any value judgment on behalf of the Medical Society, but rather to simply report on the opinions of physicians in our community. The results represent a positive and unbiased effort to address an extremely topical area of concern: the quality of laboratory services in Delaware.

ABOUT THE SURVEY

Suggested and designed by a MSD member, with the assistance of the Physicians' Advocate office, the survey consisted of 13 questions to

which a scaled response could be given (See Table 1). The laboratories to be rated included Laboratory Corporation of America (Labcorp), SmithKline Beecham (SmithKline), local hospital labs, and any other lab the physician chose to comment on. Both commercial labs, Labcorp and SmithKline, were informed of the survey and fully supported its use. The survey was administered, tabulated and results disseminated by the MSD Physicians' Advocate office.

RESULTS

Of the 1,116 surveys faxed to MSD members on November 20, 1998, 185 were returned representing a response rate of approximately 17 percent. The survey was distributed to physicians in all specialties, including those which do not regularly use lab facilities. Many of these physicians did not respond to the survey, which adversely affected the response rate.

Responses showed overall dissatisfaction with both Labcorp and SmithKline when compared to local hospital labs* and "other" labs.* In terms of market share, it is important to note that most physicians use more than one lab. The following statistics are based on our survey response market, not actual market share. Of the responses, Labcorp constituted 88 percent of the market, with 162 of the respondents using the lab an average of 63 percent of the time. SmithKline represented 77 percent of the market, with 143 respondents using the lab an average of 18 percent of the time. Local hospital labs comprised 43 percent of the market and "other" labs made up .06 percent.

When asked if a lab would be used if not required by a patient's insurance, overwhelmingly, physicians stated they would not use Laboratory Corporation of America nor SmithKline Beecham, preferring to use local hospital labs. (See Table 1)

FOLLOW-UP

These results were presented to the MSD Board of Trustees, who then directed that the study be shared with various MCOs, public health officials, the insurance department, and congressional representatives. Medical Society leadership also met with Labcorp and SmithKline representatives. The commercial labs were responsive to the survey results and discussed ways in which improvements could be achieved.

Laboratory Corporation of America

Representatives from Labcorp were concerned about the results of the survey and noted several areas in which they are working to improve service:

- All Patient Service Centers in Delaware are expected to be connected electronically by July 1, 1999.
- Labcorp is working with MCOs to develop early morning and evening hours at some Patient Service Centers.
- Training programs are in place for patient service center employees in an effort to improve information gathering at the centers.
- Billing improvements have been initiated through intermediary teams that investigate missing information before requests are passed on to practices of physicians, except for diagnosis information requests that can only be provided by the physician.
- A new telephone system is currently operational at the New Castle location.
- There are now eight service representatives to work with physicians' offices and respond to clients' needs.
- Patient Service Center locations are being upgraded and expanded. New locations will be evaluated.
- Managerial changes are in effect.

It was also noted that Labcorp conducts internal patient satisfaction surveys and uses this information to improve patient service. Plans are being made to meet with the Medical Society on a regular basis to discuss and address Delaware service issues.

SmithKline Beecham

SmithKline Beecham discussed currently available means of improving service. They stressed that once a problem is identified, they would be dedicated to addressing and improving the situation. SmithKline Beecham has been working on improving service in the following ways:

- A new representative was hired to focus solely on Delaware. He will meet with physicians, address their operational needs and assist with tracking down clinical information.
- A system of codes is in place which, when used during requisition, not only speeds up the process but renders more accurate results.
- A "Fax Always" system is in place and printers are available for receiving results.
- A monthly newsletter with updates is published.
- A pilot study to evaluate the effectiveness of Saturday appointment-only scheduling is being conducted.
- A client response center for physicians has opened in Delaware.

FUTURE ACTION

The Medical Society will continue to monitor the laboratory situation in Delaware. Along these lines, the MSD will be conducting another survey early this summer which targets physicians by specialty, realizing that many specialists do not use labs on a regular basis and most likely

did not respond to the original survey for this reason. It is the Society's goal to obtain as much information as possible on this very important topic. Meanwhile, it has been suggested that the Society select two issues of concern uncovered in the November 1998 survey and concentrate on their improvement. The membership will be kept informed of these actions.

Table 1. Summary of Laboratory Satisfaction Survey Results Based Upon Sliding Scale as Shown

CODE: NOT SATISFIED					VERY SATISFIED	
0	1	2	3	4		
Survey Question					Responses (Mean)	
					Labcorp	SmithKline Local Hospital
Accuracy of test results					2.7	2.9 3.4
Need to repeat test due to lab error or missed order					1.9	2.3 3.2
Timeliness of reports for routine chem/hemat					2.1	2.0 3.2
Timeliness of reports for microbiology					2.0	1.9 3.2
Availability and turnaround time for stat reports					1.5	1.5 3.4
Readability of reports					2.9	2.9 3.4
Copies sent to other physicians when requested					2.0	1.9 3.0
Ease of obtaining results by telephone					1.7	1.5 3.2
Ability to resolve problems by telephone					1.7	1.7 3.1
Quality of patient service center staff					1.9	2.0 3.2
Overall Satisfaction					1.8	1.9 3.2
Would you use this lab if not required by your patient's insurance?					No 68% Yes 32%	No 69% Yes 31% Yes 94% No 6%

* Local Hospital responses included: Al duPont Hospital, Beebe Hospital, Chester Community Hospital, Christiana Care Health Services, Kent General Hospital, Milford Memorial Hospital, and Saint Francis Hospital.

"Other" responses included: Community Medical Center, DE Valley Dermato-Pathology, Dianon, Limestone Medical, ShoreHealth, and State of DE DPH Lab.

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The *Delaware Medical Journal* is planning an issue dedicated to international medical volunteerism. The issue would be published in December of this year, and the editorial staff invites all physicians who have served as missionaries/volunteers to submit a manuscript describing their experience. Submissions should be between 1000 and 1500 words and should touch upon the following topics: The organization sponsoring the mission, description of a typical mission, personal and professional benefits. All other manuscript instructions can be found on page 204 of this issue. Photographs are welcome. Should you have any questions, please contact Kristine Riccardino, Managing Editor, at 302-658-7596. **The deadline for submission is August 2, 1999.**

CREDENTIALING CONNECTION IS NCQA CERTIFIED FOR TEN OUT OF TEN VERIFICATION SERVICES

CREDENTIALING CONNECTION, INC. (CCI) is very pleased to announce that it has received NCQA certification for 10 out of 10 verification services for a two-year period effective April 21, 1999. The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral health care organizations, physician organizations, and credentials verification organizations, like CREDENTIALING CONNECTION, Inc. This is a most significant accomplishment and CCI President, Lisa McCollum, is to be congratulated for her outstanding efforts in making this national certification possible. Thanks also to CCI Credentialing Coordinator, Karen E. Field, for her fine work and excellent preparations for the NCQA site visit.

The NCQA certification process evaluates a CVO's management of various aspects of its data

collection and verification operation, as well as the process it uses to continuously improve the services it provides. The certification process includes rigorous on-site evaluations conducted by a team of health care professionals. A national oversight committee of physicians analyzes the team's finding and determines certification based on the CVO's compliance with NCQA standards.

As a result of the NCQA certification, CREDENTIALING CONNECTION is now in a position to better market its credentials verification services to managed care organizations, and other health care facilities.

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Gun Control as a Public Health Issue

G. Stephen DeCherney, M.D., M.P.H.

Forget - just for a brief moment - your individual background, experiences, and worn-smooth political biases, and imagine getting the phone call that your child had been shot dead at school in the middle of the day while walking from English to Social Studies. The assassin was a classmate who was jealous of your daughter's grades/friends/team/etc (you fill in the blank). Your son was killed, never to return home again, never to leave his shoes on the stairs, his socks on the floor or join his friends entering college. If this is not sufficiently difficult to comprehend, understand that your child was killed exactly for the 15 years of values you instilled in her or him. In most of the cases in the last five years, the murderers chose their targets from among those children perceived to be successful. These were not bullies picking on the weak, to the contrary, they were those with real or imagined slights who acted on fantasies of ultimate revenge. They took their own lives, therefore,

finally joining the groups from which the killers felt excluded. In each case, the death resulted from easy access to guns. The time has come to change the culture of the United States.

Return now to your biases and let me help examine them. I have debated this issue many times and have heard a few recurring themes. I have long quietly advocated gun control. As I have not previously addressed this issue in these pages, I have been remiss. Hence, I am, in some small way, responsible for the deaths of the children in Littleton, Colorado and Jonesboro, Arkansas and everywhere else in the United States where gunplay is involved.

Argument Number 1

The first somewhat smugly expressed sentiment refers to the Second Amendment to the Constitution of the United States of America. It actually states:

"A well regulated militia, being necessary to the security of a free state, the right of the people to keep and bear arms, shall not be infringed."

G. Stephen DeCherney, M.D., M.P.H., is the Editor of the Delaware Medical Journal

This amendment is reflected in the law of a number of the original states ratifying the Constitution. The wording of the state constitution of both Rhode Island and North Carolina are almost exactly the same. Additionally, there is a large body of historical and legal expansion of the rights included in the Second Amendment. The Physicians for Social Responsibility (who won the Nobel Peace Prize) offer the following description.

"The Second Amendment does not guarantee the right to possess guns to the same extent that the First Amendment guarantees freedoms of speech, press, and assembly. Instead, it begins with a qualifying statement that limits the scope of the rest of the amendment. Unlike the First, the Second Amendment contains an expression of the purpose of the right: "A well regulated militia, being necessary to the security of a free state." The First Amendment, on the other hand, contains no such statement of purpose serving to limit the scope of the rights guaranteed.

Pro-gun groups contend that the authors of the Constitution intended the Second Amendment to protect the possession of arms, even absent a connection with the militia. However, judicial precedents have proved that the courts feel differently about the true intention of the Second Amendment. Throughout the history of our nation, the United States Supreme Court and lower federal courts have consistently held that the Second Amendment right to bear arms is related to "a well-regulated militia." **Thus, there are no federal constitutional decisions that preclude regulation of firearms in private hands.**

The absolutist view of the Second Amendment, argued by some opponents of regulation of firearms, has not been sustained by a single U.S. Supreme Court or lower court decision in our nation's history, while a series of Supreme Court and lower federal court decisions have uniformly upheld regulation of private arms. No legislation regulating the private ownership of firearms has ever been struck down on Second Amendment grounds.

The Courts on the Second Amendment

"Since the Second Amendment right 'to keep and bear arms' applies only to the right of the state to maintain a militia, and not to the individual's right to bear arms, there can be no serious claim to any express constitutional right to possess a firearm."

— *Stevens v. United States, United States Court of Appeals, Sixth Circuit, 1973*

"Construing [the language of the Second Amendment] according to its plain meaning, it seems clear that the right to bear arms is inextricably connected to the preservation of a militia... We conclude that the right to keep and bear handguns is not guaranteed by the Second Amendment."

— *Quilici v. Village of Morton Grove, United States Court of Appeals, Seventh Circuit, 1982*

Additionally, I have reviewed the records of the debates at the Constitutional Convention and in the Senate and House of Representatives for the years from approximately 1775-1809. I chose that frame because many of the authors and signers of the Constitution were active in the government they had designed. In no case, did I find any suggestion that the common citizen should be armed. To the contrary, all debate concerned the proper separation of military appointments (officers state-appointed; enlisted-national); federal appropriations for forts, payment of Revolutionary War debt, etc. Guns were sufficiently expensive so that they were highly guarded by their owners.

What is astounding about the current debate is the lack of historical context. At the time the Constitution was written, guns were needed by citizen soldiers to obtain food from game and protect against attacks from hostile native Americans (rightly or wrongly). In that era, guns were even more important to the average citizen than today. Accepting that to be true, it is clear that the Second Amendment pertained only to the militia (remember the King of England did not object to individuals hunting, only a standing militia). The Second Amendment was needed by the immediate previous experience with England, not to protect the rights of the individual citizen. It has little relevance today.

The recent regulations about acquiring guns have left many large loopholes. According to a recent article in *The New York Times*,

At a gun show, anyone with firearms to peddle can rent space for \$100 or so and sell to crowds of shoppers numbering in the thousands. Arrayed on tables as if for a brunch buffet, some of these guns are collectibles: decoratively etched hunting pieces, rifles and bayonets from the Civil War. But these days, many tables bear more sinister goods — guns popular among criminals who make up part of the show crowd. They've been lured by a loophole in current gun-control law that exempts sales of private gun collections from the record-keeping and waiting periods required of licensed firearms dealers. At a show, anyone can pay a private vendor cash for a gun and walk away with it, no questions asked.

On display at the Virginia show are handguns by the hundreds, everything from the high-end 9-millimeter pistols the cops carry to the cheap .22s they take off kids on the street. And the prices look good — guns going for \$400 in stores are tagged at \$250 to \$300. In addition, there are semiautomatic military assault rifles of all shapes and sizes. An AK-47 from eastern Europe bears a tag proclaiming it the gun Clinton banned; it remains legal to sell because it was imported before restrictions imposed by the 1994 crime bill. Then there are the notorious Tec-9s and Mac-10s — clunky, vicious-looking ugly guns that, in the 1980s, became weapons of choice for street gangs and psychotic killers. (These guns were also banned in 1994.) Individuals roam the aisles with rifles slung over their shoulders, their asking prices taped to signs on their backs or fluttering from pennants stuck in the barrels. Walking around Hugo's, one feels the anxiety and fascination one might in a porno shop. Can all this really be legal? (*NY Times* 24 May 1998)

If we cannot arm ourselves, each and every one of us, will the government become a police state? That argument is patently absurd. While we have some coordination among the various law enforcement groups, there are service and corps rivalries with their own 300-year histories. In Delaware alone, we have Wilmington Police, New Castle County Police and State of Delaware Police. We have the FBI and the Alcohol, Tobacco and Firearms Agency. All of these have armed agents. We have four disjointed military

branches numbering about two million members and each state has locally recruited National Guard troops. For those people worried about an unarmed citizenry, let them join one of the local militias still extant.

What about the 60 million guns in circulation? We will never be able to pass a law asking for the confiscation of such a large amount of valuable private property. These guns will remain in private hands even if the manufacture and sale of guns to private citizens stopped tomorrow.

Argument Number 2

The second argument usually focuses on the need for protection in the home on our property. First, please remember that legally you may only protect your person or family. You may not use any weapon that inflicts harm on another in defense of your property. The *News Journal* has recently reported the arrest of a New Castle County property owner who shot two boys riding all terrain vehicles on his property. One of those victims sustained injury to his spinal cord and remains hospitalized at Christiana Hospital. The truth about "protecting" your loved ones is exactly the opposite. Again, data from the Physicians for Social Responsibility demonstrates otherwise.

- A gun in the home is 43 times more likely to kill a family member or friend than it is to be used to kill an intruder.
- In 1992, approximately 78 percent of murder victims were killed by someone they knew. In other words the majority of the murderers were not strangers.
- In 1992, 73 females were victims of handgun homicide for every female who used a handgun in a justifiable homicide.

Who was protected here? The NRA and other groups advocating gun proliferation suggest that defenseless and weaker women need the advantage of a gun in the home. Apparently women are much more likely to be victims of guns than protected by them.

Argument Number 3

The third argument is that law makers and judges are against gun control, so the fight is hopeless. To the contrary (and from the same source):

Distinguished Jurists on the Second Amendment

"It is time we overcome the destructive myth perpetuated by gun control opponents about the Second Amendment....Federal and State courts have reached in this century a consensus interpretation of the Second Amendment that permits the exercise of broad power to limit private access to firearms by all levels of government."

— R. William Ide, III, President, American Bar Association, 1994

"To assert that the Constitution is a barrier to reasonable gun laws, in the face of the unanimous judgment of the federal courts to the contrary, exceeds the limits of principled advocacy. It is time for the NRA and its followers in Congress to stop trying to twist the Second Amendment from a reasoned (if antiquated) empowerment for a militia into a bulletproof personal right for anyone to wield deadly weaponry beyond legislative control."

— Erwin N. Griswold, former Dean of Harvard Law School, former Solicitor General, 1990

"For more than 200 years, the federal courts have unanimously determined that the Second Amendment concerns only the arming of the people in service to an organized state militia; it does not guarantee immediate access to guns for private purposes. The nation can no longer afford to let the gun lobby's distortion of the Constitution cripple every reasonable attempt to implement an effective national policy toward guns and crime."

— Joint Statement, six former Attorneys General of the United States: Nicholas Katzenbach, Ramsey Clark, Elliot Richardson, Edward Levi, Griffin Bell, Benjamin Civiletti, 1992

"The U.S. Supreme Court had several occasions to review state regulation of firearms in the context of the Second Amendment. A review of these cases reveals that the courts have uniformly held that the Second Amendment relates merely, solely, totally and only to the unhampered regulation of a state militia. It does not confer an individual right."

— L. Stanley Chauvin, President, American Bar Association, 1990

Argument Number 4

Fourth, gun control is not a public health problem and should not be advocated by physicians.

According to the Coalition to Stop Gun Violence, firearm violence is currently the second leading cause of injury-related death, behind automobile-related fatalities, in the United States. By the year 2003, CSGV estimates firearm fatalities will become this country's leading cause of injury-related death.

The CDC estimates that the lifetime economic cost — hospitalization, rehabilitation, and lost wages — of firearms violence was \$14.4 billion in 1985, making it the third most expensive injury category. The average lifetime cost per person for each firearms fatality — \$373,520 — was the highest of any injury.

Every two years, more Americans die from firearm injuries than died during the entire Viet Nam [sic] War.

Other epidemics are dwarfed by comparison. At the peak of the polio epidemic in 1952, there were 3,500 deaths, whereas firearms killed more than 38,000 Americans in 1992. More male teenagers die of gunshot wounds than all natural diseases combined.

If present rates of firearms-related deaths continue, more people will die each year from gunshot wounds than car crashes by the year 2003.

This is a public health problem of the first order. And health economists will tell you that the government must intervene when there is a market failure. It is unlikely that private competition will reduce the proliferation and use of guns. To the contrary, the incentive is in the opposite direction. The government must intervene in a public health problem. One doctor treating one case of cholera is not going to drain the swamp. As it is a public health problem, we as physicians must advocate a change in our culture.

Argument Number 5

Fifth, gun control in the United States is not much different than violence elsewhere. It is an embarrassment. The gun use advocates argue that we must escalate the use of handguns to protect ourselves.

In 1992 handguns were used to murder:

33 people in Great Britain
 97 in Switzerland
 60 in Japan
 13 in Australia
 128 in Canada
 13,220 in the United States

In summary, recent events have lead me to put to paper, for public scrutiny, a long-held view that, as physicians trying to improve the overall health of the community, we must reverse this almost uniquely American tolerance for weapons in our neighborhoods. A strict constitutional view of the Second Amendment might suggest that only the militia be armed. There are 60 million guns in circulation. They should be physically altered so that they cannot be fired. This should be phased in over a couple of decades to let the next generation be reared in a different culture.

Regarding the slogan — "if guns were outlawed, only outlaws would have guns" — I would suggest that anyone using a gun during a crime be removed from society until the time passed when guns were still easy to obtain. In other words, separate the criminals from their guns. Clearly, guns are being used malignantly by many people who were not criminals except for the availability of guns. Teenage males, filled with energy and ideals and large amounts of sometimes misguided pride will always get into

fight. Let us remove from society weapons of permanent damage, especially when the inflicted wounds are often indiscriminate. It is tough to throw a punch at more than one person at a time (somewhat foolhardy also).

To those who say it is not the guns, it is society; I respond, "hooray." I agree that we should reduce exposure to violence in every possible way. We could see less on TV, in the movies, in video games (eg play James Bond on Nintendo 64), on the Internet, and everywhere else. In my mind, this is no different than the concerted effort against cigarette smoking. It is society that glorified this habit, although individuals became addicted to nicotine.

The first phase of gun control should be handgun control. The manufacture and sale of handguns except for "militia" use should be halted entirely.

The second phase should be the permanent destruction of the firing mechanisms of extant handguns and the voluntary disarmament of all others. Anyone agreeing to bring his or her collector's gun to a registered "disarmer" would get a tax break.

Should people be allowed to hunt with rifles? Absolutely. But like golf clubs, the sportsmen themselves should regulate the size, shape and "throw-weight" of the rifles. Manufacture and sale of these rifles should be limited to those that the hunting associations designate as "officially sanctioned." The NRA should lend their endorsement to such a program.

If we do not act, together as a body of public health advocates, one of us will soon get that phone call.

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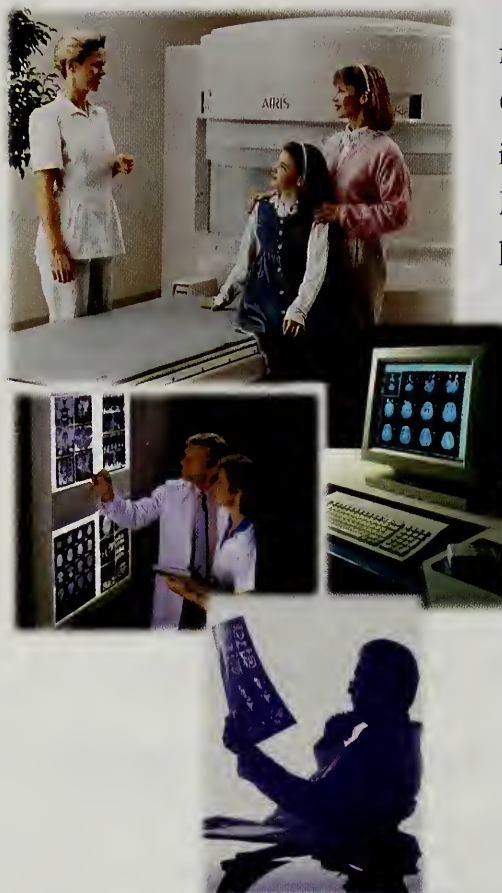
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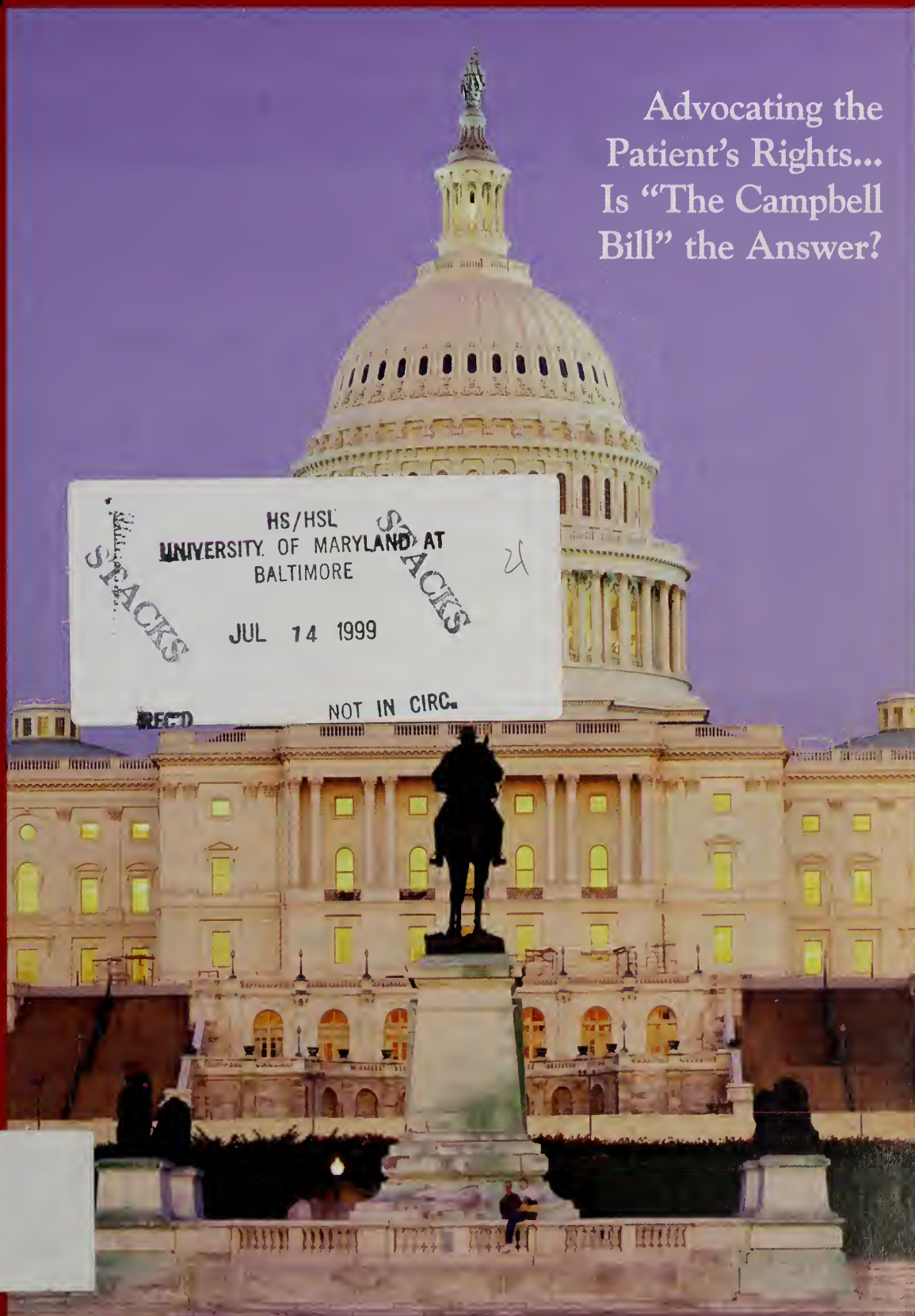
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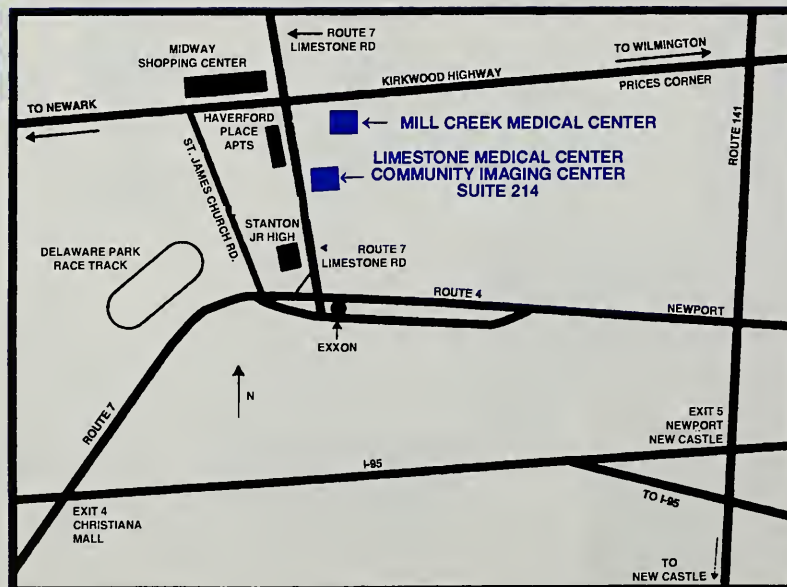
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Graphs, charts and black-and-white glossy photographs are accepted if important to the understanding of the text, but should not exceed four or five pieces. Each should have a label affixed on its back indicating its name, number, and "top." A separate legend should be provided for each. Do not write on the back, or scratch or mar them using paper clips. Do not mount them on cardboard.

Photos of patients should generally be taken in a way that obscures the patient's identity. Photos in which a patient's face must be clearly seen, however, must be accompanied by signed release forms.

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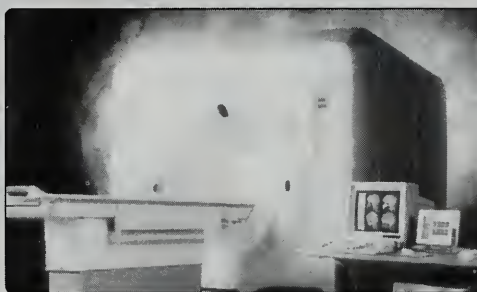
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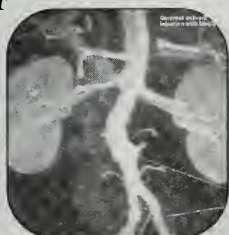
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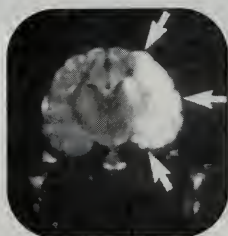
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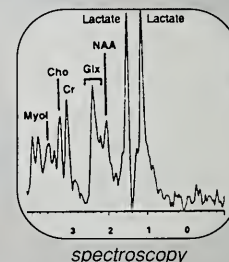
Early stroke detection

Brain perfusion can be evaluated by using first-pass Gadolinium without a radioactive substance, thereby, aiding in the early detection of brain tumors or lesions. This image shows a CVA not detected on routine MRI or CT.



early stroke

Diffusion weighted images can demonstrate an infarct 6-24 hours prior to a routine CT or MRI. Proton Spectroscopy, MRS (non-invasive chemical biopsy) shows elevated lactate levels. The greatest potential of this technology is accurate stroke detection, allowing for early definitive therapy.



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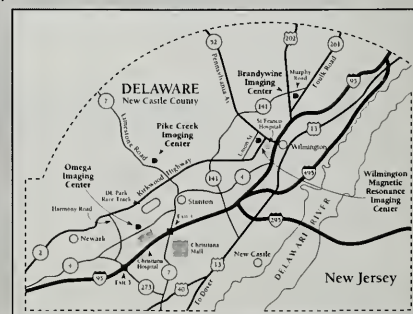
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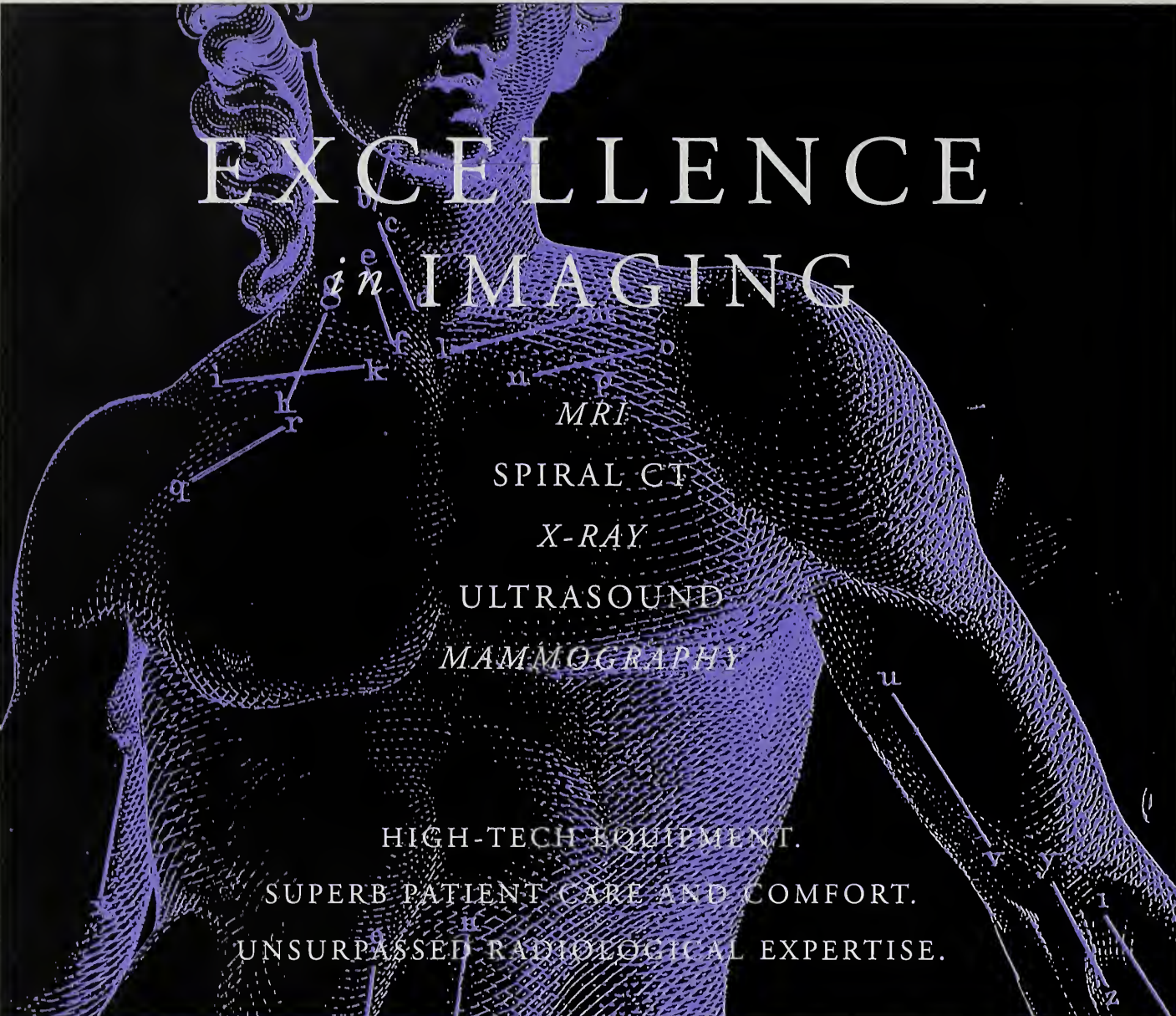
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Leveling the Field The Importance of "The Campbell Bill"

Martin G. Begley, M.D.



The biggest frustration today's physicians face in their practices is dealing with the unfair advantages that health insurance companies have. These companies can dictate the price of premiums and plan options to employers and patients, deny care or alter the recommendations of a patient's physician, and force physicians to accept contract terms that harm patients. Furthermore, they arbitrarily define the medical necessity of a procedure as the least costly of the available options.

Medical insurers get away with these abuses because they enjoy an exemption under the antitrust code that physicians and other health care providers do not have. During this session of the U.S. Congress, there is an opportunity to

correct this fundamentally unfair and dangerous situation through passage of the Quality Health Care Coalition Act of 1999 (HR 1304), usually referred to as "The Campbell Bill" after its author, Representative Thomas Campbell, a Republican from California.

During an AMA sponsored national conference call, Representative Campbell described that his goal in offering this legislation is to, "... give to medical professionals the same right to present their united front when they go to the bargaining table with an HMO. The HMOs now can present a united front and tell you to 'take it or leave it.' They are not advocating the patient's rights the way that the health care professional is, and I think that [the health professional] should be able to present a united front as well." He further explained to physicians participating in the conference call that, "Now insurers have an antitrust exemption you don't. They

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, DE. He is the president of the Medical Society of Delaware.

don't want you to have the same bargaining power on the other side of the table. My response is, 'it isn't so much the bargaining power that matters, it's who represents the patient that matters.' At present, when you sit down with an HMO, their side represents the costs ... I'd rather equalize that power and get the side that represents service – the patient – as much right as the folks who represent the costs." Representative Campbell added that he is acting in response to the concerns expressed by many of his constituents, not just those who are health care professionals.

Insurers oppose this bill, and they are doing so as they usually do, with a string of misrepresentations. They claim this bill will result in price fixing and that it violates the antitrust laws. Representative Campbell counters those arguments easily, pointing out that price fixing is not sanctioned by his bill and no antitrust laws will be violated. He can speak with authority on these legal technicalities being a Harvard Law School graduate and former Director of the Federal Bureau of Competition at the Federal Trade Commission, and Executive Assistant to the Deputy Attorney General at the U.S. Department of Justice. He does agree that this legislation will probably cut into HMO profits and the bloated compensation packages their executives receive.

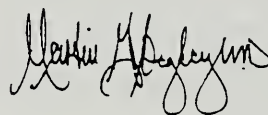
The insurers also allege that this bill would encourage physicians to strike. Such a claim is absurd as strike actions have always been prohibited by the AMA Code of Ethics.

Particularly worrisome to the insurance industry, but heartening to patients and their physicians, is the deep bipartisan support Representative Campbell has found for his bill. At the time of this writing, 97 U.S. Representatives

from across the nation have joined Mr. Campbell as cosponsors; 47 are Republican and 50 are Democrats. (Regrettably, although he agrees in principle with its intent, Representative Castle of Delaware is not a cosponsor at this time, though the Medical Society of Delaware has contacted him and requested he be one.) Given this show of support, Representative Campbell feels confident that his bill can be passed with grassroots advocacy.

I encourage all Delaware physicians to get involved and express your support for this essential legislation. You can easily do so by calling the AMA Grassroots Hotline at 800-833-6354 which will patch you through directly to Representative Castle's office. (For identification, you will need your Medical Education [ME] number which is located on the mailing label of your issue of *AMNews*.) Encourage Representative Castle to cosponsor this essential patient protection and add his "Yea" vote when the Campbell Bill comes before the House.

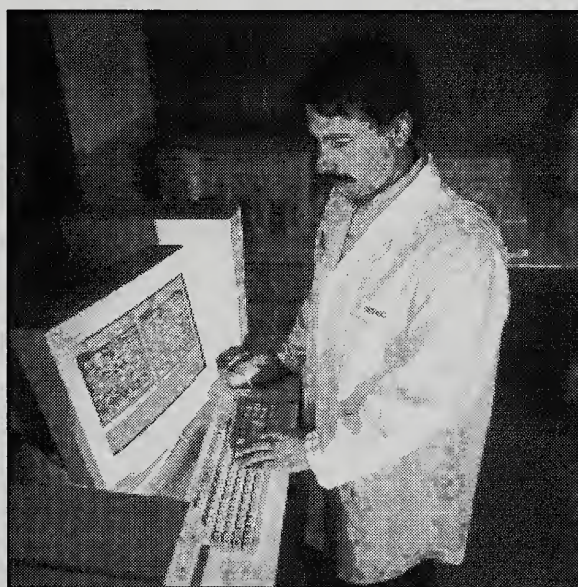
Also, follow the progress of this and other relevant government affairs through the "AMA in Washington" website, which can be accessed by clicking on the "Legislative News" button on the Medical Society of Delaware's website (www.medsocdel.org). This web page is updated constantly and has invaluable information about legislation, Congressional hearings, regulatory actions, and other activities that may positively or negatively effect you in your daily work caring for your patients.



Martin G. Begley, M.D.
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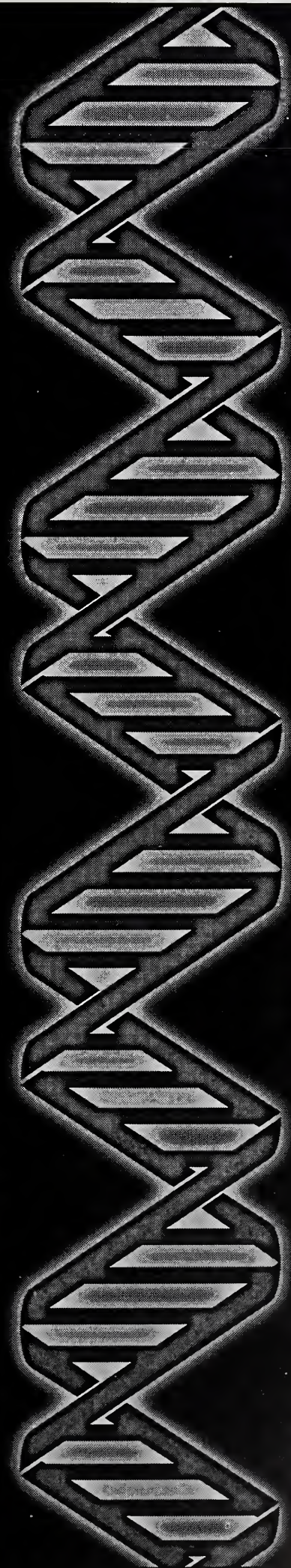
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Lower Extremity Complications: Identifying Patients with Diabetes Mellitus Who Are at Risk

Raelene E. Maser, Ph.D.^{1,3} — M. James Lenhard, M.D.²
G. Stephen DeCherney, M.D., M.P.H.^{2,3}

KEY WORDS: Quantitative Sensory Testing, Neuropathy, Vibratory Thresholds

PREVALENCE OF LOWER-EXTREMITY AMPUTATIONS

Lower-extremity amputations are costly complications for individuals with diabetes mellitus. Nationally, the incidence of lower-extremity amputations is 13-40 times greater for individuals with diabetes compared to those without.^{1,2} Greater than 50 percent of all non-traumatic amputations occur in individuals with diabetes.¹ Within a given year, there are approximately 60,000 amputations nationally related to diabetes at a cost greater than \$1 billion.³

In Delaware, hospital discharge data for 1997 at Christiana Care Health Systems, formerly the

Medical Center of Delaware, indicated 5,902 discharges where diabetes was listed as one of several diagnostic codes. Of the 5,902 diabetic discharges, there were 101 records of an amputation of the lower-extremity. These data would indicate that approximately one in 58 admissions, where the diagnosis of diabetes was indicated, resulted in an amputation. Examining the data when diabetes was listed as the primary diagnostic code resulted in the identification of 529 cases for which an amputation of the lower-extremity was reported for 66 individuals. Demographic information for these diabetes discharge cases is presented in Table 1. Perhaps the most interesting data shown on Table 1 is with regard to the average length of admission time, as it was twice as long for individuals having had an amputation when compared to other reasons for hospitalization related to diabetes admissions. In addition, although females appear to be hospitalized more frequently with the diagnosis of diabetes, males had a

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Table 1 – Demographic data of 1997 Christiana Care Health Systems Diabetes Discharge Cases

	Diabetes listed as one of several diagnostic codes	Diabetes listed as one of several diagnostic codes along with codes indicating the performance of a lower-extremity amputation	Diabetes listed as primary code	Diabetes listed as primary code along with codes indicating the performance of a lower-extremity amputation
Number	5902	101	529	66
Mean Age (years)	64	66	52	66
Gender				
(% males)	45	61	48	62
(% females)	55	39	52	38
Ethnicity				
(%white)	76	71	64	74
(% black)	21	26	33	23
(% asian)	0.5	-	0.6	-
(% hispanic)	2	2	2	3
Average Length of Stay (days)	7	14	7	14

higher amputation rate of the lower-extremities. Other investigators have also found that hospitalization rates for lower-extremity amputations were higher for males than for females.²

PREVENTION

It has been projected that 85 percent of all amputations can be prevented¹ and thus the American Diabetes Association (ADA) has developed standards for foot care to reduce the amputation rate.⁴ A major factor with regard to foot care is the ability to identify who is at greatest risk for injury (i.e., early identification of the high-risk foot) and to intervene early to eliminate the potentially traumatic situations thereby preventing ulceration, infection, and amputation.

Neuropathic and vascular deficits may contribute to the development of diabetic foot complications (e.g., ulcerations). In terms of neuropathic deficits, damage to the autonomic, sensory, and/or motor nerve fibers may act synergistically to cause foot ulceration. Peripheral autonomic neuropathy alters blood flow and skin hydration. Sensory neuropathy allows trauma to go undetected while dysfunction of the motor neurons leads to muscle weakness and changes in foot

shape and gait with new pressure points as potential areas of ulceration. In addition to neuropathy, arteriosclerosis of the lower extremities, particularly the vessels located between the knee and the foot, predisposes individuals with diabetes to amputations.

Foot care prevention programs should, therefore, be targeted with the individual's underlying risk for development of ulceration in mind. The current recommendation by the ADA is for a comprehensive foot examination, including neurologic and vascular assessment, to be performed on an annual basis with routine examination of the feet at every regular visit once individuals with high-risk abnormalities are determined.⁴ Elements of the examination (Table 2) may include but are not limited to an assessment of gait, shoes and socks, skin hydration and color, foot shape, structural deformities, lesions, nail care, sensation level, and foot pulses.

The determination of the presence or absence of protective levels of sensation is fundamental to the routine evaluation. Protective sensations include both adequate touch and pain sensation with the hope that injuries will be prevented and continued use of an injured extremity will be prohibited to reduce any further injury.⁵ The

Table 2 – Elements of a routine foot examination

Assessment Category	Examine
History	<i>Changes since last visit</i> - Wounds - Pain - Visual acuity
Gait	<i>Ambulation aids</i>
Shoes and socks	<i>Fit and condition</i> - Wear patterns - Type
Foot appearance	<i>Hydration</i> - Dry - Excessive perspiration <i>Color</i> - Red or blue when dependent <i>Skin temperature</i> <i>Toenails</i> - Ingrown - Overgrown <i>Structural deformities</i> - Hammertoes - Bunion <i>Lesions</i> - Ulcers - Plantar warts - Corns - Calluses
Sensory function	<i>Sensation</i> - Sense of touch - Pain - Position - Vibration
Circulation	<i>Palpable pulses</i>
Risk level	<i>Low, intermediate, high</i> (see Table 3)
Plan of action	<i>Potential interventions</i> - Continued monitoring - Teaching (e.g., daily foot inspections) - Treatment - Referral - Footwear prescription - Follow-up (e.g., more frequent foot exams)

assessment of sensory levels may include: pain (pinprick), vibration(128-Hz tuning fork), pressure (monofilaments), and proprioception.

Small sensory nerve fibers process pain and temperature sensations. Individuals who experience sensory loss due to small fiber involve-

ment may have evidence of undetected trauma such as blisters on the feet from ill-fitting shoes or foot burns from bath water. Pain may be assessed by using a disposable safety pin and asking the patient if it is sharp or dull.

Large sensory nerve fibers process information with regard to proprioception and vibratory sensation. Vibration sensation can be assessed using a low-pitched tuning fork of 128 Hz (Figure 1 - Page 254). After tapping the head of the tuning fork on the heel of the examiner's hand, the end of the handle of the tuning fork is applied to the distal metatarsal head of the patient's great toe. The patient is asked to indicate when the vibration stops. Vibration should be felt for at least 15 seconds but usually 20 to 25 seconds. Proprioception can be tested by having the patient indicate the direction of passive movements of the terminal interphalangeal joint of the great toe.

Semmes-Weinstein monofilaments⁶ (Figure 1 - Page 254), also known as the Carville Foot Exam, can be used to assess pressure. The monofilaments are an effective and reliable tool for identifying patients who are at risk for injury of the lower-extremities. Each monofilament is made of nylon. They vary in thickness but are the same length. Based on the difference in thickness, a different force is required to bend each monofilament. The most common monofilament used is the 5.07, which

requires ten grams of linear force to cause it to bend. Regions on the plantar surface of the foot that are at the highest risk of breakdown, such as the metatarsal heads and the great toe, are usually tested. Patients who cannot consistently feel the touch of the 5.07 monofilament have lost the protective sensation. Insensitivity to the

Table 3 – Categorization of risk.

Risk Category	Results of Clinical Assessment	Potential Interventions
Low	Protective Sensation Intact	<i>Educational intervention</i> a. proper footwear selection b. importance of good glycemic control c. smoking sensation d. risk of sensory loss
Intermediate	Protective Sensation Lost	<i>Intervention</i> e. a-d from above f. daily foot inspections g. early wound care h. non-weight bearing exercises i. careful footwear evaluation
High	Protective Sensation Lost <i>plus</i> foot deformity or ulceration	<i>Intervention</i> j. a-g from above k. prescription footwear l. closer follow-up m. referral

5.07 monofilament has been shown to be associated with an 18 times greater risk of foot ulceration.⁷

In addition to neurological testing, the comprehensive foot examination should include a vascular assessment with palpation of pulses of the lower-extremities.⁴ A vascular consult may be necessary for disabling claudication or a non-healing ulcer.⁴

RISK CATEGORIES

The use of a standardized assessment form that lists specific screening activities to be performed will provide an easy means for comparison of patient results from visit to visit. Several different assessment forms can be found in the literature.^{5,8} A standardized assessment form facilitates the separation of patients into potential risk categories (e.g., low, intermediate, or high [Table 3]) thereby helping to determine the amount of educational intervention that may be warranted.

For example, it may be sufficient for individuals who are in the lowest risk category with protective sensations intact just to be educated with regard to the importance of good glycemic control, good foot hygiene, proper footwear and the avoidance of lower-extremity trauma.⁵ The re-

sults of the Diabetes Control and Complications Trial (DCCT) clearly demonstrated that glycemic control plays a significant role in the development of neuropathy.⁹ Of all the end-points of

DCCT, neuropathy showed the clearest clinical benefit from intensive glycemic control. Patients need to know that prevention of nerve damage is the best defense against amputations.

Individuals who are in the intermediate risk category with a loss of protective sensation need to be taught daily foot inspections. The importance of daily foot inspections should not only be taught but patients need to be shown how to perform them properly. Table 4 lists important educational tips for foot care. Although giving the patient a set of written instructions to be taken home with them is important, merely giving a list of dos and don'ts without individual instruction is not effective.¹⁰ Patients will also have to be instructed that exercise is still an important part of their overall diabetes management. Weight-bearing exercise (jogging, prolonged walking, treadmill, step exercises), however, may have to be curtailed or avoided and replaced by non-weight bearing exercises (swimming, bicycling, rowing, chair and upper body exercises) when protective sensation of the foot has been lost.¹⁰

Individuals who are at highest risk for the development of lower-extremity amputations, those with a loss of protective sensations and foot deformity, may need extensive education, close follow-up and referral to other health care professionals. Referrals may include: (a) the

podiatrist for management of foot problems, (b) the pedorthist for fitting, shaping, and molding of shoes, (c) the physical therapist and exercise physiologist for aid in designing exercise programs, (d) the nurse educator to provide extensive foot care education, and/or (e) the social worker for assistance in job-related problems.⁵ In addition, therapeutic shoes may be necessary for these individuals. The purposes of therapeutic shoes include: limiting joint mobility, accommodating deformities while reducing excessive pressure and ensuring even distribution of weight.¹¹ For those patients covered by Medicare Part B, 80 percent of "reasonable" fees will be reimbursed. A recent published report indicates that there is low utilization of this footwear benefit.¹²

EDUCATIONAL INTERVENTION

Studies have shown that intensive educational intervention does increase foot care compliance and results in fewer foot problems requiring treatment.¹³ Thus, perhaps the best prevention for lower-extremity amputations is a well-informed patient who has been taught how to reduce his/her own risk. Unfortunately, current data indicate that 92 percent of diabetic patients are not having documented foot examinations,¹⁴ leading to an assumption that these individuals may not be receiving foot care education either. In order to reduce the amputation rate, recommendations with regard to foot care must be practiced by both physicians and patients.

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Table 4. Educational Tips for Good Foot Care

Shoes

- Leather or canvas shoes
- Heels should be wide and low (<1 1/4" in height)
- Toebox covered with 3/4" between tip of the great toe and shoe
- Purchase shoes during the afternoon when foot is slightly swollen
- Wear new shoes no more than two hours at a time
- Examine the inside of the shoes for foreign objects, torn linings, and rough areas
- Inspect shoes for abnormal wear patterns
- Buy shoes that fit, not shoes that are too small

Socks

- Cotton, cotton-blend, or wool socks without thick seams or holes
- Avoid socks with elastic bands, they reduce circulation

Foot and Nail Care

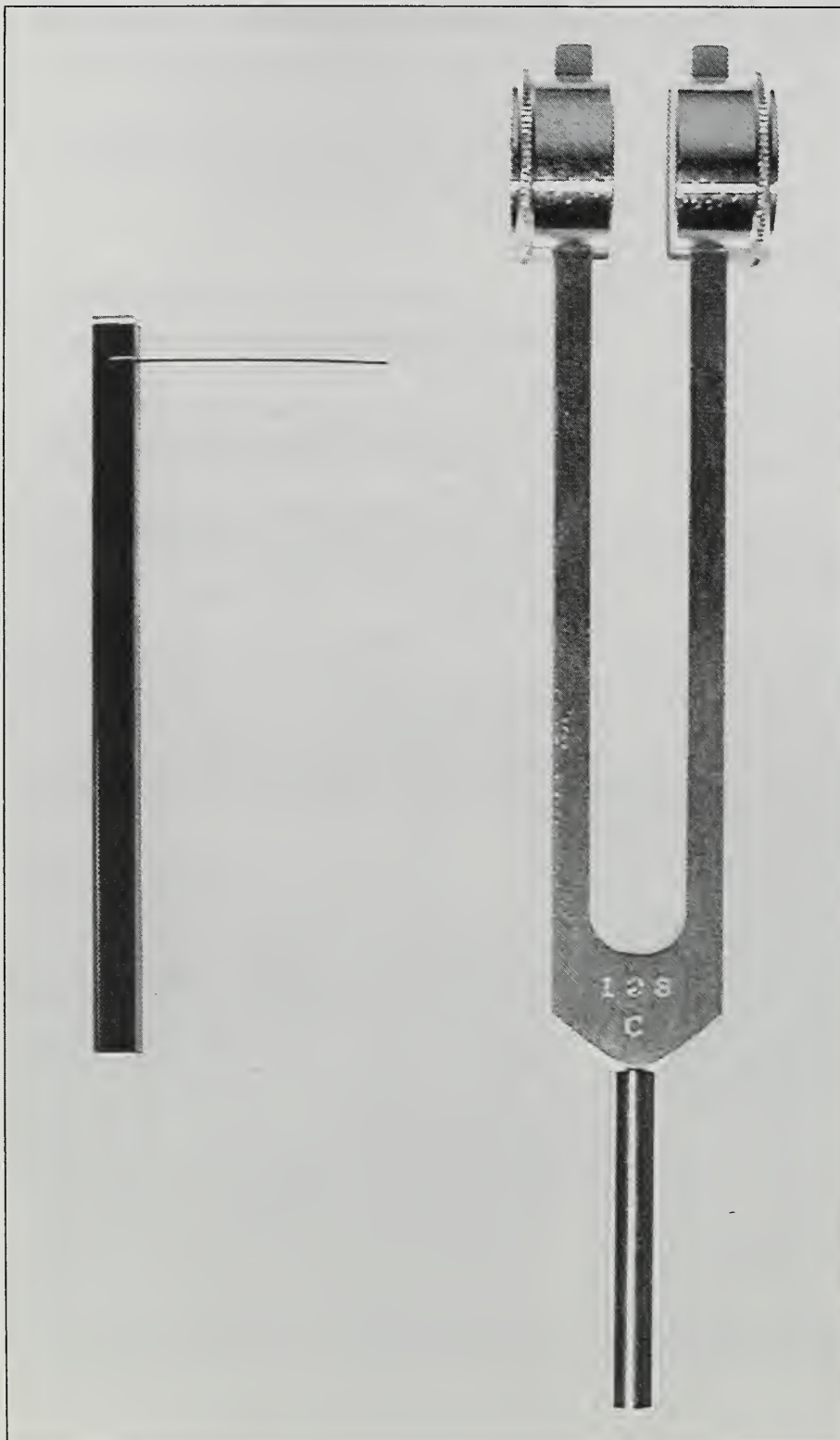
- Cut nails straight across, follow the contour of the toe
- If patient cannot see well or cannot reach the feet, have a family member cut the nails or go to a community center for low-cost foot care
- Clean and dry feet especially between the toes
- Inspect feet daily for blisters, cuts, and scratches
- Check between the toes for redness
- If skin is dry use a thin coat of lubricating cream but not between the toes

Avoid

- Avoid temperature extremes: test bath water with elbow rather than foot or hand
- Avoid heating pads and hot water bottles
- Avoid walking barefoot (hot beaches, cement, asphalt)
- Avoid use of chemical agents for removal of corns and calluses

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Figure 1. A 5.07 monofilament is shown on the *left*. This device is used by applying the monofilament perpendicular to the skin with enough force to cause the filament to bend for approximately one second. Test regions of the foot that are at highest risk for skin breakdown (e.g., metatarsal heads). A 128 Hz tuning fork is shown on the *right*.



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A Multidisciplinary Approach to the Treatment of Childhood Obesity

Melinda S. Sothorn, Ph.D.¹ — T. Kristian von Almen Ph.D.¹ — Heidi D. Schumacher, R.D.¹
Robert M. Suskind, M.D.¹ — Uwe Blecker, M.D.^{1,2}

Childhood obesity is a chronic disease that is associated with significant co-morbidity. Successful treatment and prevention of childhood obesity requires a multidisciplinary approach, including diet, nutrition education, behavior modification, and exercise.

We studied 87 children (39 males, 48 females; aged 7-17 years) enrolled in a one-year multidisciplinary weight reduction program. Subjects were placed on a very low calorie/high protein diet, a moderate-intensity progressive exercise program, and behavior modification sessions for 10 weeks.

Measures were taken at baseline 10 weeks, and 1 year. Significant anthropometric changes in weight, percent of ideal body weight, and percent body-fat were observed in all patients.

We conclude that a multidisciplinary weight reduction program including diet, behavior modification, and exercise is an effective instrument to achieve weight loss in obese children and adolescents.

INTRODUCTION

Childhood obesity is a multifaceted public health problem associated with significant medical and psychosocial complications.¹⁻³ Current estimates indicate that one-third of all children in the western industrialized world aged one to five years are overweight.⁴ The issues, which impact the treatment of childhood obesity, are complex. The role of genetics, the association with metabolic disorders and cardiovascular disease and the increasing number of obese children make the study of childhood obesity of critical importance to children. In 1990, with over one-third of adults being considered obese, the direct health care cost of adult obesity was estimated at 45.8 billion dollars, approximately 6.8 percent of total health care dollars.^{5,6} Like-

wise, pediatric obesity is an increasingly prevalent health problem for American youth.⁷ Current research indicates that, if untreated, 70 percent of obese children, 10-13 years of age, will become obese adults.⁸

Obesity is a chronic disease that is associated with hypertension, hypercholesterolemia, diabetes, and an increased incidence of musculoskeletal injuries.^{9,10} Recent studies suggest that obese children and adolescents are at increased risk of future cardiovascular disease.¹¹ The adverse psychological consequences of childhood obesity include lowered self-esteem and increased depression ratings.¹² Obese children are often labeled ugly, stupid, and dirty by their peers and family.¹² It has been observed that weight loss positively impacts the psychosocial implications of childhood obesity.

Therapeutic approaches to the treatment of childhood obesity that are associated with long term success include very low calorie diets, nutrition

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education, behavior modification and exercise. Successful prevention and treatment of childhood obesity may be dependent on altering behavioral patterns, improving the nutrition practices, and increasing physical activity in obese children.

Treatment recommendations for childhood obesity include family based dietary interventions, specific behavior modification techniques, a reduction in sedentary behavior, and participation in activities that are high in caloric expenditure.¹³ There are a small number of controlled clinical intervention studies in obese children.¹³ The results of the studies vary, and, therefore, limited conclusions can be made. However, based on these findings, diet, exercise, and behavior modification may be considered important factors in pediatric obesity treatment.¹³

We describe our experience with a multidisciplinary, four-phase pediatric weight management program.

MATERIALS AND METHODS

Subjects

Eighty-seven subjects (39 males, 48 females; aged 7-17 years) were enrolled in a one-year weight-reduction program. Patients were recruited through referrals from their primary care physicians or via self-referral. Subjects were not enrolled if weight was less than 120 percent of ideal body weight (IBW). Subjects were also excluded if there was evidence of cardiovascular disease, diabetes, or other chronic systemic diseases. Subjects who returned for 10-20 week follow-up blood testing are included in this data analysis.

A comprehensive history was taken and a physical examination was performed prior to baseline. Individual ideal body weights were calculated by measuring weight and height. The weight percentile that matched the subject's height percentile was determined according to the Na-

Table 1. Selected Variables at Baseline, 10-Week and 1-Year.

<u>VARIABLE</u>	<u>BASELINE</u> <u>Mean±SEM</u>	<u>10 WEEKS</u> <u>Mean±SEM</u>	<u>1 YEAR</u> <u>Mean±SEM</u>
Weight (kg)	79.86±3.00	70.70±2.68	71.44±3.04*
Height (cm)	152.72±1.50	154.02±1.51	157.07±1.83
IBW (%)	175.99±3.70	150.98±3.40	146.14±3.49*
BMI (kg/m ²)	33.34±0.80	28.85±0.72	28.34±0.76*
SFT (%FAT)	46.16±0.96	38.89±1.13	35.03±1.22*
BIA (%FAT)	44.86±0.70	41.84±0.68	39.95±0.75**
Abbreviations: BMI=body mass index; SFT=skinfold thickness; BIA=bioelectrical impedance assessment * p<0.0001 (ANOVA, repeated-measures design) ** p<0.001 (ANOVA, repeated-measures design)			

tional Center for Health Statistics (NCHS) percentiles.¹⁴ The subject's actual weight was then expressed as a percentage of IBW based on an equivalent weight and height percentile. Subjects were subsequently classified as mildly obese (120-149 percent IBW), moderately obese (150-199 percent IBW), or severely obese (200 percent IBW or greater).

Ethical Standards

All methods and testing procedures were approved by the Institutional Review Board of our institution. Subjects and legal guardians read and signed an approved consent form.

Treatment Program

All subjects participating in the program began with an intensive 10-20 week period that focused on acute weight loss. At the beginning of the program subjects received handbooks that explained all aspects of the acute weight loss. The handbooks were color-coded according to the initial severity of obesity. The color-coding was used as positive reinforcement as subjects dropped from one obesity classification level into a less severe category. During the acute intervention phase, subjects generally achieved a lower category of obesity, i.e., from severe to moderate, from moderate to mild, and from mild to less than 120 percent IBW. A weight-maintenance program was prescribed once the next lower level or phase of obesity was achieved.

Acute Weight Loss: During this period, subjects attended a weekly two-hour weight reduction clinic. They received diet instruction, nutrition education, exercise intervention/instruction, and behavior modification sessions.

Diet: Patients were started on a protein-sparing modified fast (PSMF) diet, which consisted of two g protein/kg IBW/day (up to 100 g/day) and supplied approximately 800 kcal/day. Lean meat, fish, or chicken provided the prescribed protein. To induce ketosis carbohydrate intake was limited to a maximum of 20-25 g/day. Two cups/day of vegetables, excluding vegetables of high-starch content, were allowed. All participants received supplemental calcium carbonate (Tums®, Smith Kline Beecham Pharmaceuticals, Philadelphia, PA). Two 500-mg tablets taken twice a day provided 800 mg of elemental calcium. The diet was also supplemented with potassium chloride (10-20 mEq twice daily) and a daily multiple vitamin/mineral supplement.¹⁵ Subjects were encouraged to drink at least two L of water or sugar-free beverages per day.¹⁵ Dietary adherence was monitored through self-reported urine ketone records. Subjects were taught how to check urine for ketones each morning and to record whether ketones were present. These records were presented by the subjects, along with weekly weight loss information, at weekly meetings to reinforce the perception of success

and to assist therapists in assessing participant compliance.

Exercise: The subjects were given a home-based exercise program including an instructional video. Subjects and family members participated in 30-45 minutes of moderate intensity exercise during the weekly intervention meeting. The exercise intervention program, called "Moderate Intensity Progressive Exercise Program" (MPEP), has been described elsewhere.¹⁶ In brief, MPEP consists of supervised exercise classes (30-40 minutes) of varying types during each weekly clinic visit. The home-based program is individually designed according to the subject's level of obesity. It includes moderate intensity aerobic, strength and flexibility exercises which gradually increase in duration (time per session) and frequency (sessions per week) through the tenth week of the program. Exercise record cards listing the frequency, duration and type of exercise are kept by each subject and checked weekly by the exercise physiologist.

Behavior Modification: The behavior modification program has been described elsewhere.^{16,17} In brief, the behavior modification component focuses on strategies such as self-monitoring, cue elimination, stimulus control, symptom substitution and goal setting in facilitating behavior change. Discussions, role plays and educational materials are used to highlight family and peer perceptions and support. Changing attitude and motivation are also explored during sessions. The Culture Free Self-Esteem Inventory (CFSEI) was used to evaluate changes in self-esteem, as it has been demonstrated to be an effective measure of changes as a result of intervention efforts. The CFSEI has been found to correlate highly with the Beck Depression Inventory.¹⁸ It yields a general, social, academic, and parent self-esteem score. The patients' ratings were compared to Battle's normative samples.^{17,18}

Anthropometric Measurements

Anthropometric measurements were performed on enrollment into the program and at 10-20 weeks. Weight and height were measured weekly. Weight was determined with an electronically calibrated scale (Deteco-USA, Webb City, MO). Height was determined with a calibrated stadiometer (Holtain, Ltd., UK, Dyfed). Body mass index (BMI) [wt(kg)/ht(m)²] was calcu-

Figure 1a. Levels of Obesity (Baseline)

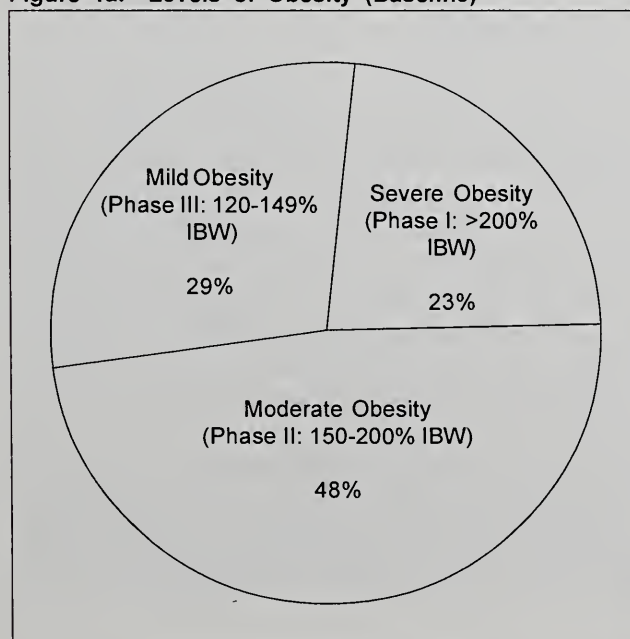
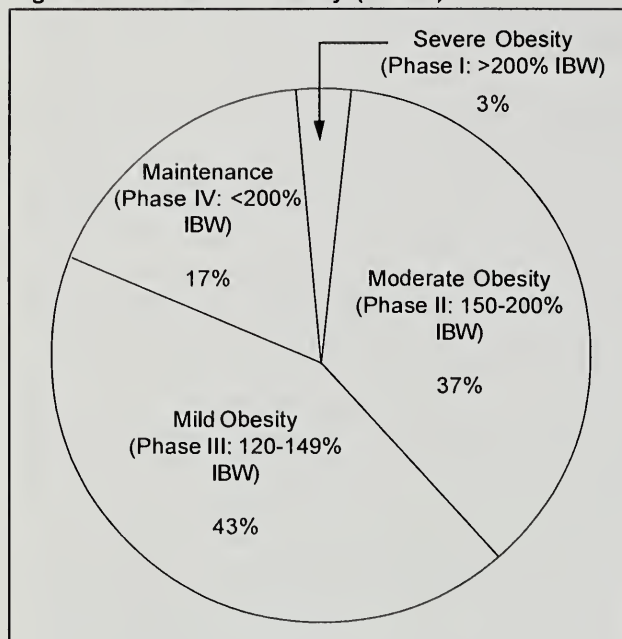


Figure 1b. Levels of Obesity (1 Year)

lated at each time point. Measurements of triceps and subscapular skinfold thickness were obtained using Harpenden calipers (Holtain, Ltd.).¹⁹ Three measurements were recorded for each site and the mean value was calculated and recorded. Relative body fat (RBF), expressed as a percentage of body weight and lean body mass (LBM) in kilograms, were then determined with a formula by Slaughter and colleagues.¹⁹ This formula included specific regression formulas for age, sex and race.

Statistical Analysis

Anthropometric data for all subjects were analyzed with Student Paired t-tests.

RESULTS

All patients (N=87) experienced significant weight loss and a reduction in body fat percent ($p<0.001$) with no decrease in lean body mass (Table 1). The program resulted in an overall significant reduction in percent IBW at ten weeks which was maintained at one year ($p<0.001$) (Figures 1a and 1b). All of the subjects experienced a substantial reduction in percent IBW with the majority of subjects reducing level of obesity from severely overweight (greater than 200 percent IBW) to moderately over-

weight (150-199 percent IBW), moderately overweight to mildly overweight (120-149 percent IBW), and mildly overweight to normal body weight (less than 120 percent IBW). At one year only three percent of the subjects remained in the morbidly obese category (Figure 1b).

Subjects enrolled in the program also experienced an overall improvement in self-esteem and a significant reduction in depression after 10-36 weeks in the program ($p<0.001$) (Figure 2).

DISCUSSION

Obesity in children remains a pressing public health concern as it may track into adulthood and is associated with high blood pressure, morbidity, increased risk of cardiovascular disease and non-insulin dependent diabetes.²⁰ Risk is amplified for underserved, ethnically diverse children.

A universally acceptable definition for childhood obesity does not exist. Recently, Poskitt²¹ suggested the utilization of the body mass index (BMI) as a simple, inexpensive, and easily available indicator on the obese child. The BMI is calculated by determining the weight (wt) in kilograms (kg), the height (ht) in meters (m), and applying the following formula: $BMI = wt(kg)/ht(m)^2$. Although this measure is useful as a common indicator across nutritional studies of childhood obesity, its clinical application is questionable.

Nieman²² classifies adult obesity into three categories: mild (120-140 percent ideal body weight [IBW]; $BMI=25-30 \text{ kg/m}^2$), moderate (141-200 percent IBW; $BMI=30-35 \text{ kg/m}^2$), and severe (greater than 200 percent IBW; $BMI>35 \text{ kg/m}^2$). We have experienced success utilizing these classifications in obese children with a minor modification in the mild (120-149 percent IBW) to moderate (150-200 percent IBW) to severe (greater than 200 percent IBW) range.

It is possible for the BMI to decrease via an increase in height without a substantial decrease in weight. The growth velocity works in conjunction with either maintenance of weight

or loss in weight to reduce the level of obesity and therefore the BMI value. One of the limitations to this study is the absence of an obese control group. This would have enabled the researchers to determine the typical progression of the BMI over a one year period. However, there is information that suggests that the BMI of obese children increases when not treated. Also, it is important to note that the BMI value ranking per national percentiles naturally increases as age increases.²³ The BMI value for less than the 85th percentile for an eight year old is much lower than that of a 17 year old. Therefore, because the natural progression of the BMI over the childhood years is to increase, illustrating a significant decrease has more to do with weight loss or weight maintenance than growth. Furthermore, similar trends are observed when other weight for height indices are utilized (e.g., percent ideal body weight).

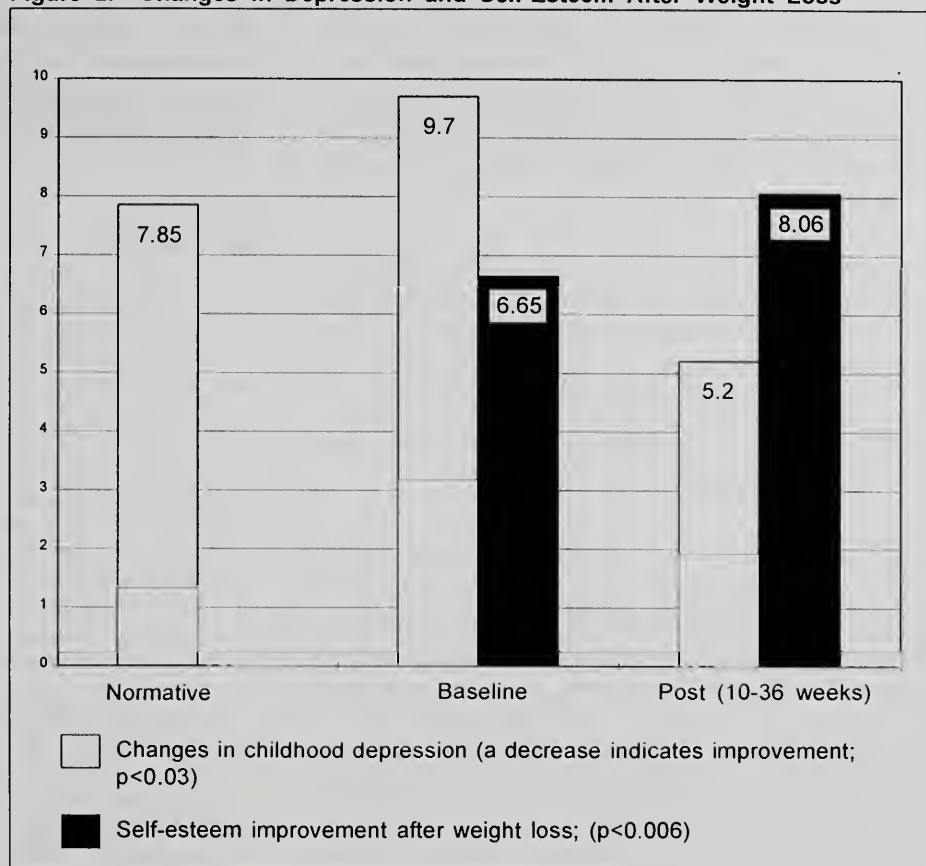
Genetic differences, neurotransmitter disorders, hormonal abnormalities, resting metabolic rates, body-weight set points, energy expenditure during activity and digestion, and familial factors have an impact on the development of childhood obesity.²⁴ Recent research indicates that genetic factors play an important role in the development of childhood obesity. Current studies indicate that the genetic factors which influence obesity account for as little as 20-30 percent in adoption studies and as high as 60-90 percent in twin studies,^{25,26} with environmental factors accounting up to 80 percent of the basis of childhood obesity. Environmental factors include increased caloric and fat intake, and sedentary behaviors, such as television viewing.²⁷⁻²⁹ Research suggests that obese children and ado-

lescents have decreased levels of physical activity and increased psychosocial problems.⁹⁻¹⁰

American children have a diet so consistently high in saturated fat and cholesterol that their blood cholesterol levels and fat intake remain significantly higher than those of children in other developed nations.³⁰

The described pediatric weight management program is an individualized approach to the prevention and treatment of childhood obesity conducted in a group family setting. Increased self-esteem and self-confidence are the most important changes promoted by the program. Obesity can lead to a significant lack of confidence and depression if not treated at an early age. The program serves as a support group for overweight children who tend to be more motivated to lose weight once they see other children dealing with the same problem. The intervention promotes a significant improvement in body composition, physiologic function and biochemical parameters.

Figure 2. Changes in Depression and Self-Esteem After Weight Loss



These improvements are maintained at one-year follow-up. Almost every child who completes the program reports an improved self-image. Through the program components, nutrition, behavior modification and exercise, the students accomplish their health and weight loss goals.

Furthermore, our results support a continued use of exercise in combination with diet for child and adolescent obesity, which is similar to results from previous studies.³¹ Other investigations have yielded similar results in subjects participating in a weight loss program incorporating a restricted caloric intake.^{32,33}

Very low calorie diets have been used extensively in adults. Although the safety of ketogenic diets in children and adolescents has been illustrated in studies conducted in the inpatient hospital setting, the use of such diets in pediatric patients in an outpatient setting should still be considered experimental. Patients with severe conditions of obesity may benefit from these types of diets. We recommend that their use be limited to patients greater than 150 percent of ideal body weight. Other researchers, however, have suggested that only patients greater than 180 percent of ideal body weight be prescribed ketogenic diets. Close medical supervision is a requirement. Additionally, careful monitoring of blood chemistries, bone density and lean body mass is warranted. The potential health risks of a ketogenic diet can be minimized with appropriate medical supervision and adequate calcium, protein, potassium, and vitamin intake.¹⁵ Furthermore, exercise has been shown to reduce some of the risk factors that are associated with severe caloric restriction (i.e., reductions in muscle mass and resting energy expenditure).³⁴ The described program includes both a structured exercise regimen of aerobic, strength, and flexibility exercises and methods to increase daily activity patterns, and thus reduce sedentary behaviors. In addition, the patients are repeatedly evaluated for blood chemistries, body composition, and aerobic capacity.

We conclude that a multidisciplinary weight reduction program including diet, behavior

modification, and exercise is an effective instrument to achieve weight loss in obese children and adolescents. **The use of a ketogenic diet should be limited to practitioners experienced with this type of diet.**

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Fibromyalgia: How Disabling?

Peter V. Rocca, M.D.

Why did we do this? Why did we become physicians, nurses, and therapists? Hopefully, the answer to this question is - to improve the quality of human life by lessening the suffering imposed by disease. The question then becomes, "what is a disease"? Are diseases limited to those pathophysiologic processes which potentially lead to irreversible tissue destruction? If so, then a great many of our patients would be told to just "grit your teeth and bear it" simply because our radiologist or pathologist colleagues cannot identify tissue destruction. This not only seems a particularly heartless view but also screams of arrogance. It is highly unlikely that medical technology has reached the pinnacle of its research and identified all that can go wrong with the human condition. Perhaps disease could best be defined as any set of symptoms which limits one's functional ability. This broader defi-

nition would allow health care professionals the opportunity to offer their services to those countless number of unhappy people who, while not dying, are hardly "living" either. Sadly, fibromyalgia is, given what I see day after day in my office, an extremely common condition in our society which inflicts a great deal of unhappiness. Sadder still is the skepticism which many of my fibromyalgia patients have to face from my colleagues.

"This is a Yuppie disease," one of my patients was told by a doctor. If so, then I wonder what so many of my indigent patients with fibromyalgia have.

"It's all in your head," another of my patients heard. While that may be true, there is some research to suggest that there may be impaired high-energy phosphate bond storage in fibromyalgia muscle tissue.¹ If, however, this research is faulty, then this physician would be

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correct about fibromyalgia's "head" localization. I believe that the same could also be said of Parkinson's or schizophrenia - two very limiting conditions.

"Fibromyalgia is just a waste-basket term" proclaimed a third healer. The American College of Rheumatology has established strict criteria for the diagnosis of fibromyalgia² which calls for the methodical exclusion of other chronic painful conditions. Placing patients in "waste-baskets" would not be of much therapeutic use.

"This is the same thing as depression. Look, he's got you on an antidepressant." Studies done at tertiary care referral centers,³ where presumably the most severe patients are seen, demonstrate that only about 25 percent of patients that had been diagnosed with fibromyalgia in the community fulfilled the criteria for depression. This is not surprising given that living with chronic pain stifles happiness, and, in addition, the results of this study hardly equate the two as 75 percent of patients did not have depression. Furthermore, I doubt that any psychiatrist would treat his or her depressed patients with 10 to 30 mg a day of amitriptyline which is a typical dose for the patient with fibromyalgia. It is theorized that antidepressants are beneficial in fibromyalgia as well as depression due to the fact that both processes share a serotonin pathway in their genesis.

Skepticism aside, there are many patients in our society who have chronic, poorly localized pain in the setting of fatigue. Call it what you will but these patients exist and will continue to exist. Outside the field of rheumatology, there are related conditions to fibromyalgia. Neurologists treat many with migraine headaches. Gastroenterologists treat many with irritable bowel syndrome. Urologists treat many with interstitial cystitis. The list is rather lengthy. Dismissing these individuals as neurotics helps no one and shirks our Hippocratic responsibilities to our patients. As health care professionals we

have a responsibility to ease human suffering, regardless of its physiology.

There should be no ethical dilemma in deciding what to do with this type of patient requesting treatment. The physician seeing such a patient should either initiate appropriate treatment or ensure that the patient is referred to an individual trained in managing the disease's nuances. The much more difficult ethical issue is: what do we as health care professionals do when such patients with non crippling, non life-threatening conditions request our assistance in their application for disability? Put another way, what is our responsibility to society vis-a-vis that to our patients? None of us have difficulty in sanctioning the status of disability for a patient who has lost tissue irreversibly, e.g., the blind, the amputee, the stroke patient, etc. But what if a patient has pain, fatigue, diarrhea, headaches, or dysuria and no tissue loss?

Based on the results of controlled clinical trials, the symptoms of fibromyalgia can be significantly ameliorated by two interventions: medications which modulate serotonin in the nervous system and aerobic exercise. In other words, encouraging activity is beneficial to the affected patient. Swimming twenty minutes three times a week is, however, a far cry from stocking shelves with cans of tomato sauce forty hours a week at the local Super-Fresh. On average, I receive about two requests a week from Delaware Disability Determination Services for medical information on patients. I would estimate that about 80 percent of these applications are from patients I have diagnosed with fibromyalgia. Unfortunately, the state does not keep totals of recipients of benefits by diagnostic category and thus there is no way to know just how many recipients with fibromyalgia or related conditions are living in this state. Records do show that of 12,304 disabled workers on the state's rolls in 1997, 2,466 were disabled due to disorders of the musculoskeletal system.⁴ How many of these 2,466 people had fibromyalgia is un-

known. It has been my observation that most of my patients who apply are eventually granted benefits even if initially denied.

I don't know what fibromyalgia "feels like" and I hope to God that I never do. I do know that what we call fibromyalgia in 1999 is a big problem which costs society a considerable amount of money in health care costs as well as time lost from work. We are first and foremost to be advocates of our patients. We are, however, also members of a community which can be made bankrupt by overspending. The way in which we as health care professionals balance our responsibilities to our patients and to our community is the art of medicine and a matter of much philosophical debate.

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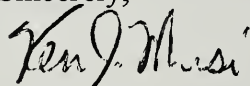
To: Medical Professional
From: Ken J. Musi
Re: Health Care Real Estate in Delaware

Within the field of medicine, physicians specialize in order to best meet the medical needs of their patients. As a commercial real estate agent, I have done likewise for equally important reasons. By becoming an expert in the field of real estate specifically suited for the Health Care industry, I have helped hundreds of physicians and medical groups acquire, sell or lease space appropriate for medical practices and health related facilities.

Since beginning my career in 1989, I have built a client base that has come to value the knowledge and expertise that I have acquired through this specialization in real estate. Many Physicians, Residential real estate agents, attorneys, accountants, and other Commercial real estate agents also recognize the importance of such a specialty, with much of my business resulting in referrals from this important professional network. Some of my clients have included: Blue Cross Blue Shield of Delaware, the duPont Hospital for Children, St Francis Hospital (Franciscan Family Care), Riverside Hospital, Christiana Care, First State Orthopaedics, The Delaware Heart Group, Gastroenterology Associates and many more. In addition, I have also assisted many physicians in finding suitable sites to develop an office building either for their business or for the purpose of investment. Whether assisting physicians just completing residency, or business managers of large practices, my real estate expertise in the Health Care field can be of tremendous value. As a member of the DMGA (Delaware Medical Group Managers Association), I remain involved in the concerns and issues facing the medical community providing an extended benefit to all of my clients.

Should you have a building suitable for Health Care use, please call me if you plan to sell or lease. Within my database may be someone needing exactly what you have. If you are looking for space to start a practice, move a practice, or add additional locations, check with me first as I will probably be aware of a building or location perfect for your needs. My goal is to provide the highest quality of service while offering you the greatest level of expertise as it relates to your real estate needs in leasing, buying or selling property in the specific area of Health Care. I look forward to hearing from you.

Sincerely,



Ken J. Musi



Life

E. Wayne Martz, M.D.

*The views expressed by Dr. Martz in this editorial
are not intended to represent the views of the
Delaware Medical Journal nor its publisher,
the Medical Society of Delaware.*

If you have ever been back to your *alma mater* for a reunion, chances are that you have met someone who seems to remember you very well, but you haven't a clue who he is. However, after you talk with him for a while in the local coffee shop or pub, it starts to come back to you. It may be the voice, the accent, the tilt of the head, the laugh or some off-hand opinion expressed. Gradually, your old buddy emerges. He really hasn't changed at all. You recognize the person, the personality. It is the way he thinks, and acts, and expresses himself that makes him who he is.

I used to think as I watched my mother age, "If there is indeed some sort of afterlife or heaven, how will she come back?" If given a choice, she might prefer to be as a young bride — whom I never knew — or as the mother who raised me, cleaned my ears and finger nails, taught me manners and love. Or, would she be as this

untidy, simple, forgetful 95 year old who had moved into my mother's body? The other woman exists only as a concept in my mind, a spirit, if you will, or what it is that determines who we are before those neurons start to stick together and form plaques and tangles, and we disappear as a person.

As best we know, those most basic association pathways are laid down in the first few years of life. We are pretty much an inert lump when we are born, with several kinds of sensors to let us interpret our surroundings. Within days, or weeks, or certainly within months, we start to react to and interact with those surroundings other than as a simple electrochemical recoil from noxious stimuli, like an amoeba. To my way of thinking, this is when we start to become a person. That seems to be the way the ancients felt, and it worked out pretty well over thousands of years. Life was divided into two pretty distinct parts: embryonic life from conception to the clamping of the umbilical cord — a sort of

E. Wayne Martz, M.D., is the Editor Emeritus of the Delaware Medical Journal.

trial period to see if a real person could be put together — and real life, which starts at birth and continues to last breath. It has long been recognized that, for one reason or another, many conceptions are unable to survive. I believe the commonly accepted figure is about 40 percent. Through all of human history, in every country and culture, life dated from the day of birth. The developing ovum went through the stages from the 2-4-8-16 cell blastomere to the three layers of ectoderm, mesoderm and endoderm, and then the infolding of the notochord followed by the development of the circulatory system. From there, it proceeded through all the limb buds and organ development, as “ontogeny recapitulated phylogeny.” The thought never existed that the parts under construction were the same as the finished product, any more than one would think that the frame starting out on the automobile assembly line was the same as the finished automobile. It isn’t! It was recognized that the closer you are to the end of the assembly line, the more likely it is that you could pull it off the line and put the finishing touches on later, so there was a concept of viability. But if the kidneys or lungs are not mature enough, or the enteric tube isn’t hitched up, it isn’t going to work. The neural pathways can’t work until they are complete, and that is some time after birth.

Now, we have a group that says human life starts at conception. They refer to the 8 or 16 cell blastomere as “a baby,” and use this idea to bolster their preconceived notions about interfering with the process. What is their authority for this different interpretation of a long accepted phenomenon? Throughout history, there have been groups who felt they knew the will of God, usually by referring to some holy writ or scripture, or at least by some long standing agreed-upon creed. But disagreements and misunderstandings always crept in. The ancient Romans thought Christians were drinking blood and eating human flesh because of the scriptural description of the Eucharist, and in the Spanish Inquisition they excused their murders as saving souls, forcing conversion by torture, then killing the convert before he could recant. When Edward Jenner proposed vaccination, the ones who bombed the vaccination clinics and

killed the medical personnel believed plagues and epidemics were imposed by God as punishment for sin. The Bible said it happened at Sodom and Gomorrah and elsewhere, so immunization was against God’s will. In the 1850s, those who opposed obstetrical anesthesia cited the book of Genesis stating women should bring forth children in pain. Queen Victoria put a stop to that in a hurry when she announced she was having chloroform for the births of her children. But the adherents of the present change in thinking are the first that I am aware of that do their bombing and killing solely on the basis of a direct revelation from the Almighty.

I don’t quarrel with their right to their opinion, and must admit that it has a catchy ring and a certain spurious logic that tends to silence the opposition. However, there are good religious authorities who disagree, and I consider the other opinions at least as valid. The general public, hearing the new party line repeated over and over again without refutation, come to believe it is an accepted fact, that human life begins at conception. This provides their self-justification for the murders of those who disagree. It is time someone spoke up and set the record straight. When they start having funeral services for every late menstrual period or miscarriage, I may be a little more convinced of their probity and not just their ability to rationalize.

With the progress being made in genetics, for the first time in human history the possibility exists that we may be able to control, or even eliminate certain disastrous genetic disorders and their tragic opportunity costs. When you consider that a third of all pediatric hospitalizations and half of pediatric deaths are genetically based, that is a lot of suffering, anguish, effort and money to flush down the drain simply on the basis of a concept that may be faulty to begin with: yet we can hardly push ahead in genetics without losing some fertilized ova. What is the ethics, compassion and morality of forcing defective ova to be born to a brief life of pain and torment? We as physicians need to speak up and lead the way back to the original concept that embryonic life and human life are separated by a very important birth process.

Larks and Owls

Balu H. Athreya, M.D.

I wish to share an interesting article I read in the *British Medical Journal*. The title was "Larks and owls and health and wealth and wisdom." (*BMJ* 317: 1675-1677, 1998). This is a cross sectional study on the sleeping patterns of 1229 men and women over the age of 65 from England. The authors tried to correlate health-related outcomes in people with early sleeping habits with those of late night owls. The conclusion was that there was no special advantage to either sleep habit. At the end of the article, the Journal had a special feature call "Key Messages" which I wish to share with the readers:

- "Proverbial advice about life-style has the authority of tradition and the merit of brevity, but is rarely based on systematically collected evidence.

- In a nationally representative cohort of elderly people there was no indication that those who lived by the maxim 'early to bed and early to rise' were advantaged as regards state of health, material circumstances, or wisdom.
- Sleeping for more than eight hours a night was associated with increased mortality, but it mattered little whether sleep was taken in the early or late part of the night
- There is no justification for early risers to affect moral superiority."

I liked the final key message the most!



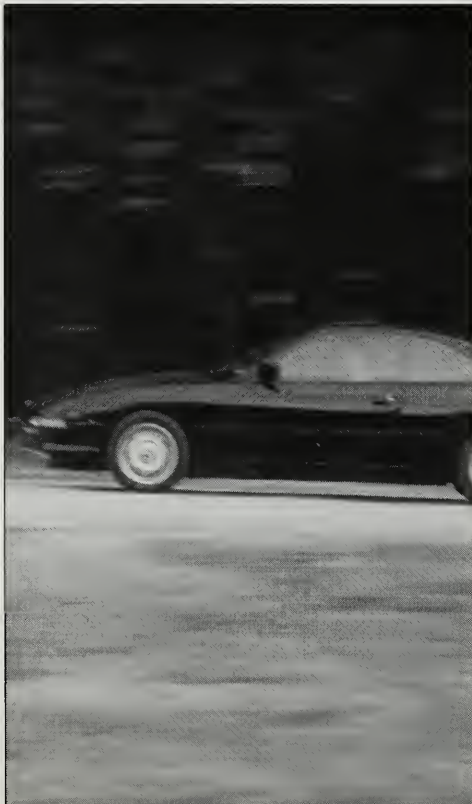
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Between the Raindrops

(David V. Pecora, M.D. - Vantage Press, N.Y., 1998 - 248 pp. - \$21.95)

David Platt, M.D.

David V. Pecora, M.D., is one of us, a member of the Medical Society of Delaware. This book is his autobiography. He grew up in Yonkers, N.Y., a member of a very closely knit extended family of Italian immigrants, for whom study and hard work were the keys to success in life.

The book opens with an intimate portrayal of growing up in Yonkers beginning in 1916. Later comes a tour of Italy with not only a description of all the places visited, but a detailed discussion of the history of the country from Roman times to the present.

As the war clouds gathered, he went to college at Columbia and medical school at Yale, followed by a surgical residency at Case Western Reserve.

David Platt, M.D., is a member of the Medical Society of Delaware and is a contributing author to the Delaware Medical Journal.

Then came active duty in the U.S. Army Medical Corps. The narrative continues with the details of his war time surgical experiences and the countless incidents of personal self-sacrifice which he witnessed. But, in addition to that, he discusses the history of the events leading up to the war, and the ways he thinks that war and future conflicts could be prevented.

Between the battles he found his Dorothy, a surgical nurse on the front lines. From then on the story of their life together runs through the pages of the book.

After World War II ended, he had a series of thoracic surgery fellowships including those at New York Medical College and Yale New Haven Hospital. He stayed on as a member of the faculty with responsibilities for teaching and for surgical research.

The latter was his passion. His salary was meager, but augmentation by moonlighting in emergency rooms helped him support his family, which now included two little girls.

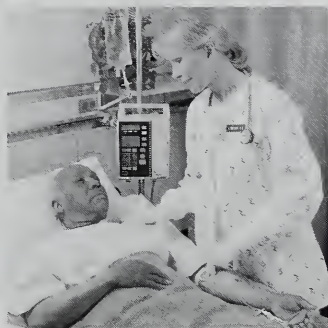
For a considerable part of his career he was chief of cardiothoracic surgery and research at the Ray Brook Hospital in Saranac, New York, where he invented new ways of surgical treatment of tuberculosis patients. The discovery of effective antibiotic treatment of tuberculosis eliminated the need for these elaborate surgical procedures, and for his research. He left Ray Brook Hospital and had a series of tours of duty as chief of cardiovascular and thoracic surgery at Veteran Administration hospitals around the country. The last of these assignments was at the local V.A. Hospital in Elsmere, where he was kept busy with surgery, research, and training of surgical residents. Here he was happy, until increasing bureaucracy and the appointment of a non-physician as director of the hospital induced him to resign. He then tried private surgical practice, but found grief in the attitude of local surgeons who did not welcome competition and, in their hospital credentialing roles, restricted his operating privileges, despite his lifetime record of surgical practice, research and teaching.

Dr. Pecora is versed in many areas besides medicine. He describes, for example, a tour of Europe with his family. For each of the countries they visited, he gives a running account of not only the present physical attractions, but of the country's history and of its historical role in the development of greater Europe.

The most interesting parts of this book, for me, are the philosophical dissertations sprinkled surprisingly through its pages. These range from observations on the vagaries of human nature, including honesty and the lack of it, to details of present medical care and how it should be changed, to present day politics on our national scene.

The author has had a varied and full career. Above all, he is a serious thinker who has paused to consider problems. When you add to that his ability to tell a tale interestingly enough to stop your putting the tale down, the result is an interesting book.

The last paragraph explains the book's title, *Between the Raindrops*. He quotes the old saying that into each life a little rain must fall, then goes on, "We had much rain, but had not been swept away. It is not the raindrops which are important; it is what lies between them."



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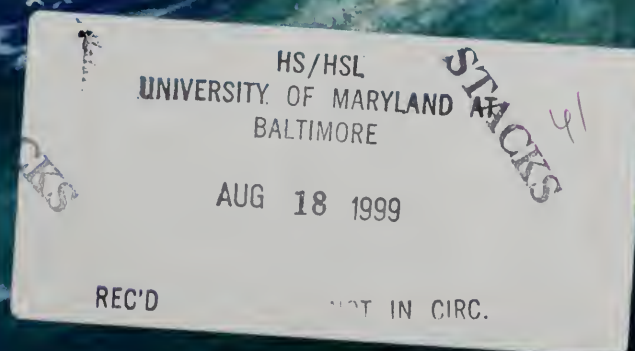
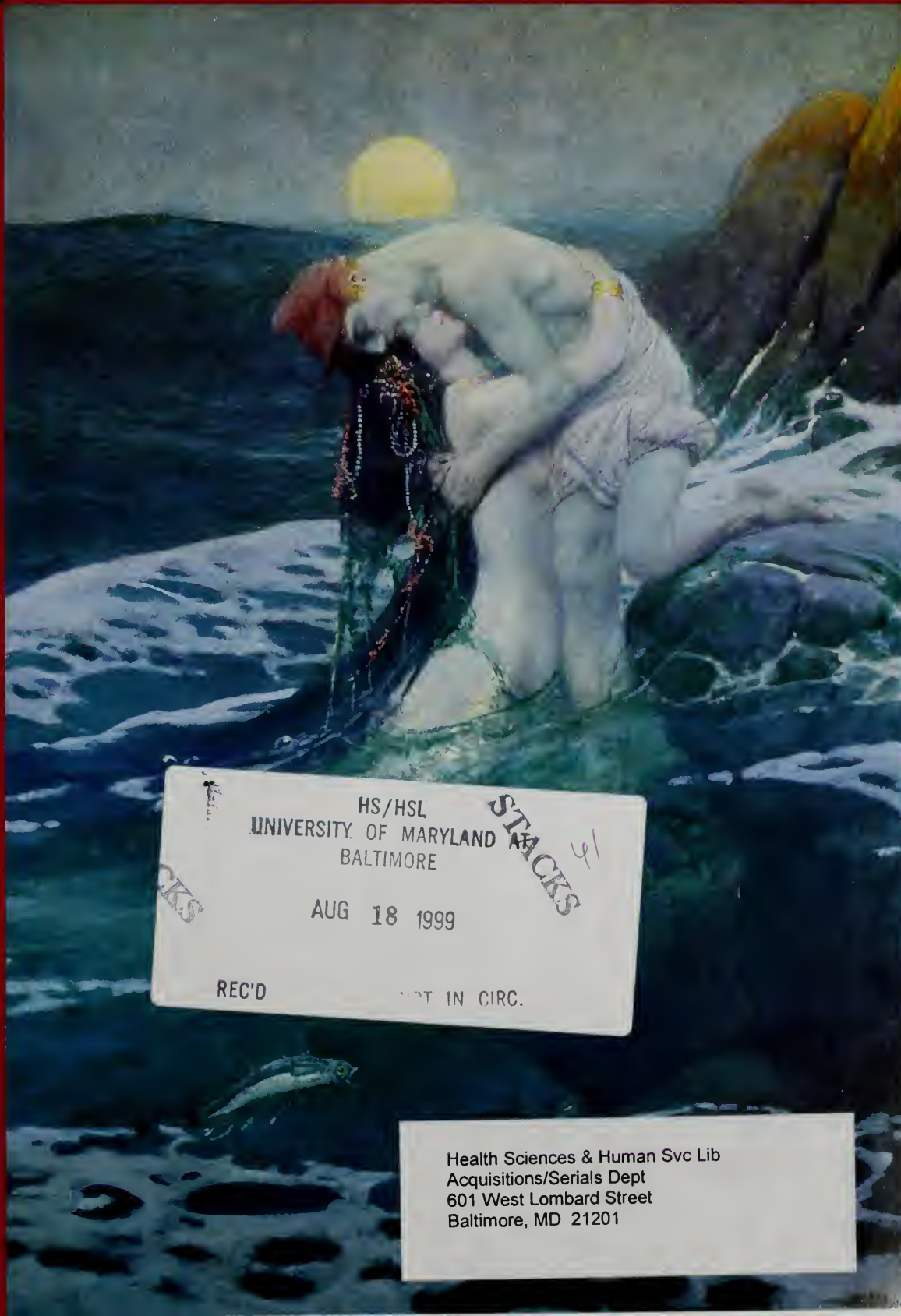
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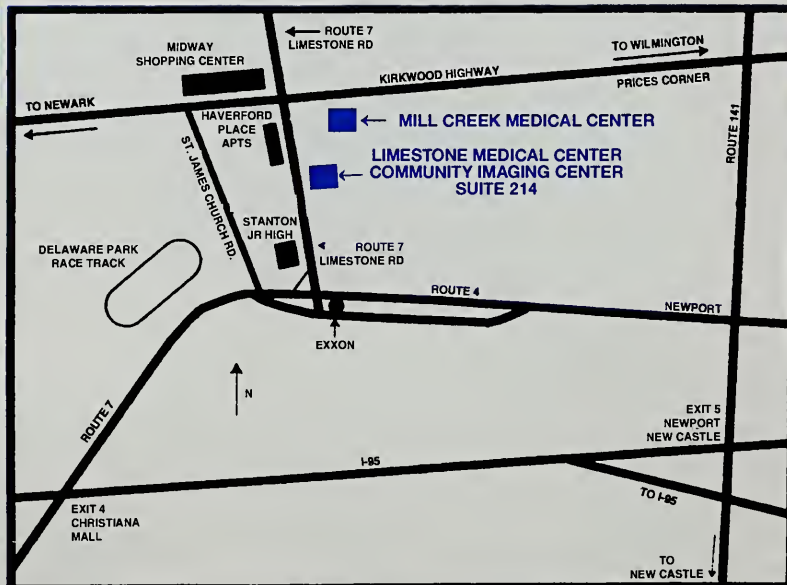
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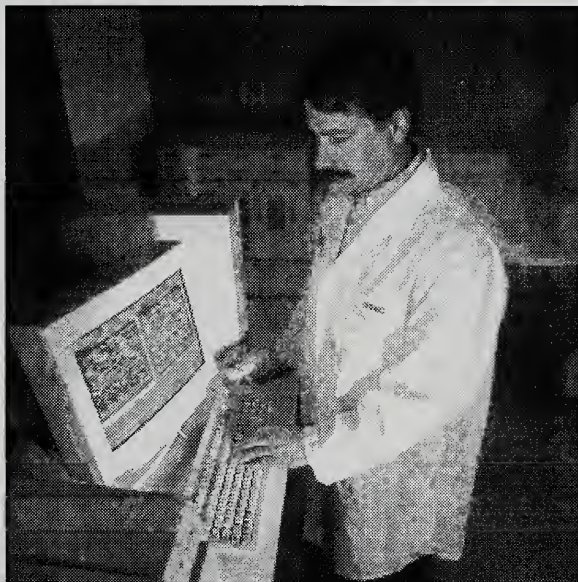
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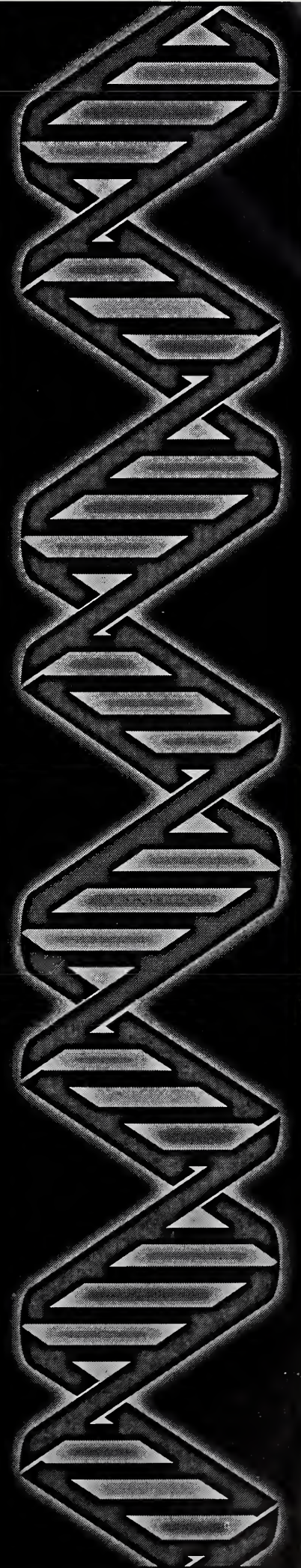


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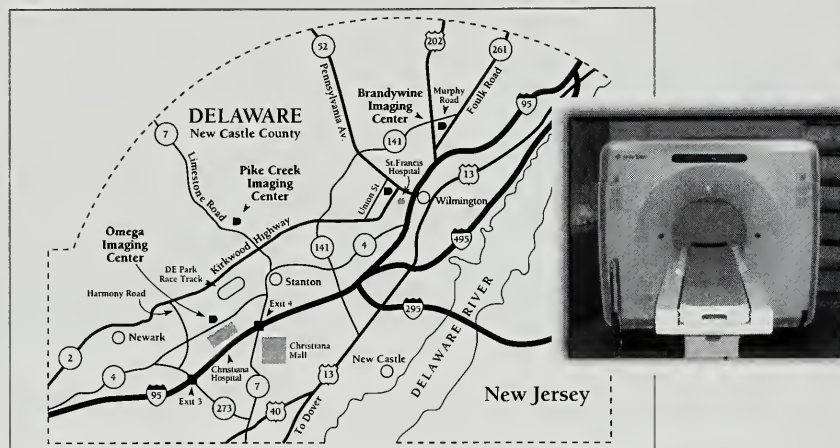
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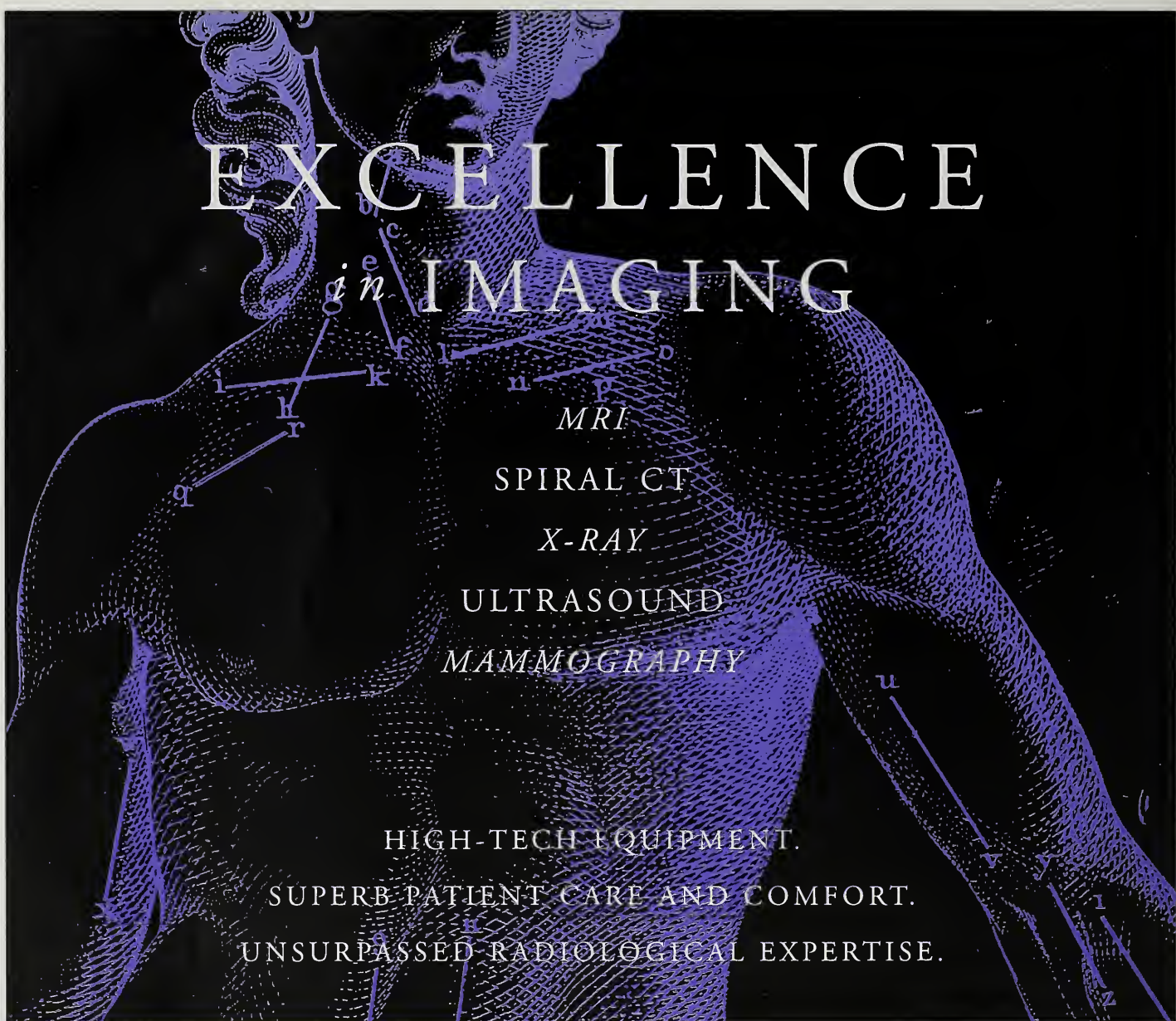
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Is the AMA Trading Your Black Bag for a Lunch Bucket?

Martin G. Begley, M.D.



If the average practicing physician expects to be fitted for a hard hat and steel-toed boots, it is no wonder given the commentary that followed the AMA Board of Trustees' recent passage of a resolution to form a National Negotiation Organization for physicians. Unfortunately, the coverage so far has been neither complete nor entirely accurate, and it has caused concern among the public and physicians. So why was this, heretofore inconceivable, action taken and what may be its consequences?

Any physician can answer the first part of that question by merely recounting the many unreasonable stresses he or she faces daily in practice: the constant intrusion of insurers into medical

decision making; the application of assembly line production techniques to patient care in a way that is inefficient, harmful, and unethical; the burdensome and costly paperwork foisted upon physicians; gag rules that prohibit physicians from telling patients when their HMO rejects a procedure that would be best for them; documentation of harm, sometimes fatal, done to patients by insurers' decisions; and, the abusive "take-it-or-leave-it" negotiating stance physicians face when dealing with these companies. These and other abuses have prompted a physician outcry demanding corrective action.

As reported by Dr. Stephen Permut, who leads our Delaware delegation to the AMA, the outcry has been voiced at many previous AMA meetings. For years, many resolutions calling for creation of a collective bargaining unit were introduced but rejected. This year, the Board of

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, DE. He is the president of the Medical Society of Delaware.

Trustees of the AMA felt compelled to respond to the members' demands that collective bargaining be investigated especially now that more and more mergers of insurers have occurred putting physicians in an even worse negotiating position. The AMA Board of Trustees also did not want physicians to turn to labor unions as other professional groups have done.

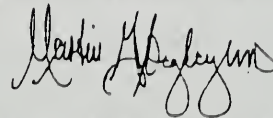
What has been the reaction so far? I can assure you I have gotten a lot of comment from the members of the MSD. Most of the initial comment has been vigorously critical of the AMA's action. However, the majority of members with whom I have spoken have expressed something akin to what Dr. Michael DeBakey wrote on the subject in a *Wall Street Journal* editorial page article, "It is a drastic step but relief from unrelenting power sometimes requires a drastic step."

The public's response, I have found, parallels that of physicians. The more vocal, especially the media have voiced criticism. However, more support physicians as they want to assure excellent medical care for themselves. These patients also understand the most important point that has been all but lost in the heat of the discussion—the AMA has not called for the formation of a union, but a National Negotiating Organization. The main goal of the NNO is to combat threats to quality patient care and reverse the harmful effects of insurers. It is not to seek

economic benefit for physicians. Physicians must make that distinction clear to all their patients, explaining that if this were a true union the AMA would reserve for physicians the right to strike. The AMA hasn't. Furthermore, physicians' strikes have always been forbidden by the AMA Code of Ethics and that prohibition has been firmly reiterated in all discussions of the NNO!

Here in Delaware, your society is fully in support of the AMA's ethical guidelines. Also, the MSD Board of Trustees has voted to form an ad hoc committee to study the NNO to determine what would be best for Delaware patients and physicians in compliance with our state statutes.

Well, what can physicians expect from all of this? Perhaps nothing. Physicians may be so limited by existing antitrust laws and regulations that little can come out of this effort. However, this may be the chance for physicians to collectively make excellent patient care, not the profits of corporations and the bloated salaries, options and perks of their executives, once again the primary goal of medical practice.



Martin G. Begley, M.D.
President

Over-The-Counter Yellow Ultraviolet Light Protective Lenses: Any Benefit for Individuals with Diabetes Mellitus?

Raelene E. Maser, Ph.D.^{1,3} — M. James Lenhard, M.D.²
Joseph Frattarola, B.E.E.⁴ — G. Stephen DeCherney, M.D., M.P.H.^{2,3}

INTRODUCTION

Diabetic retinopathy, a microvascular complication of diabetes mellitus, is the leading cause of blindness among Americans aged 20 to 74.¹ The prevalence of diabetic retinopathy is highly associated with increased duration of diabetes. Greater than 60 percent of individuals with type 2 diabetes and almost all persons with type 1 diabetes after 20 years duration have some form of retinopathy.¹

Diabetic retinopathy progresses from mild non-proliferative (e.g., micro-aneurysms) retinopa-

thy, to moderate-to-severe non-proliferative retinopathy characterized by vascular closure, to proliferative retinopathy with growth of new blood vessels.^{1,2} Loss of visual function results from the consequences of diabetic retinopathy with an increased risk of blindness. It has been estimated that blindness is 25 times more frequent in persons with diabetes than nondiabetic individuals.³

Results of the Diabetes Control and Complications Trial showed the importance of good glyce-mic control in preventing and delaying the progression of diabetic retinopathy.⁴ In addition, the American Diabetes Association recommends that persons with diabetes be examined routinely for the development of diabetic retinopathy with specific guidelines for initial and subsequent ophthalmologic evaluations.¹ Therapy with laser photocoagulation has been shown to be beneficial in reducing the risk of further loss

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⁴Vision Publications, Inc, Landenburg, PA

Table 1. Characteristics of the study population (n=200)

	Males (n=95)	Females (n=105)	p-value
Age (yrs)	51±15	50±16	NS
Duration(yrs)	13±12	12±10	NS
Body Mass Index(kg/m ²)	30±8	32±9	NS
Type 1 (%)	35	40	NS
Type 2 (%)	65	60	
History of laser photo-coagulation therapy (%)	13	15	NS
NS : nonsignificant Values are mean±SD			

of vision in a number of patients with retinopathy. Thus, clinical goals must concentrate on identifying individuals at risk of visual loss and ensure that appropriate treatment is offered to reduce the risk. In addition, continued research for new therapeutic agents is desperately needed for the prevention and treatment of diabetic retinopathy. Until such agents are developed, improving an individual's ability to see with an optic aid could potentially affect their quality of life. In this study, we determined if the simple use of yellow ultraviolet (UV) light protective lenses would improve an individual's ability to read a standard eye chart. It is thought that these lenses would provide improved contrast. Disorders such as diabetic retinopathy can cause a reduction in vision when there is less contrast despite the fact that there is normal conventional visual acuity.⁵

METHODS

A convenient sample of 200 patients was examined at the Diabetes and Metabolic Diseases Center, Christiana Care Health Services, Wilmington, DE. A patient's sight for distance was assessed 20 feet from a standard eye chart (i.e., Snellen chart). All testing was performed with

the patient's corrective lenses or contact lenses, as prescribed for their distance visual acuity, in place. Testing, with and without yellow UV protective lenses (Figure 1), was performed in three different settings of illumination (i.e., sunlight-simulated artificial light-Vita-Lite® 120 watts, two-third reduction of the simulated artificial sunlight (40 watts), and fluorescent light). During testing, the room was sealed from other light sources. The patient's ability to correctly identify each letter on the Snellen's eye chart from the line marked 20/50 to the line marked 20/10 was assessed

for each type of illumination. Order of assessment was performed in a random fashion for all types of illumination and whether the patient began the testing with the lenses on or off was also performed randomly. The percentage of correctly identified letters, with and without the yellow UV protective lenses for each setting of illumination, was compared using the Wilcoxon sum rank test for paired comparisons. Clinical information (e.g., height, weight, history of laser photocoagulation therapy) was obtained from the patient's chart.

RESULTS

Demographic and clinical data describing the patients included in this study are shown in Table 1. No differences between males and females were seen for age, duration or type of diabetes, body mass index, or history of laser

Table 2. Percentage correct with and without yellow UV protective lenses (n=200)

	% correct with lenses	% correct without lenses	p-value
Simulated artificial sunlight	60.8	58.7	<0.001
Two-third reduced simulated artificial sunlight	55.2	53.8	<0.001
Fluorescent light	55.2	53.4	<0.001

photocoagulation therapy. Table 2 reveals the results of each patient compared to himself/herself with and without the yellow UV protective lenses in the three different settings of illumination. Individuals read one to two percent ($p < 0.001$) better with the lenses in place for each setting of illumination.

Twenty-seven percent of the individual's sight was improved greater than five percent (5-27 percent) in the simulated artificial sunlight setting, while 24 percent of the individuals revealed greater than five percent improvement in both the two-third reduced simulated sunlight setting and the fluorescent light setting. Analysis of the data for specific factors that might differ between those with greater than five percent improved ability to see with the lenses compared with those who had less than five percent improvement or who did not see better with the yellow UV protective lenses revealed no univariate differences for age, duration, type of diabetes, or history of laser photocoagulation therapy in the artificial sunlight or fluorescent light settings. In the two-third reduction of artificial sunlight setting, individuals who were younger (46 versus 52 years old, $p < 0.05$) appeared to have the most improvement with the yellow UV protective lenses.

SUMMARY

The use of yellow UV protective lenses did improve some individual's ability to see even under artificial and controlled circumstances. Each test, although given in random order, cannot be interpreted to demonstrate the full range of benefit. The improvement for most was modest.

Figure 1. Yellow UV Light Protective Lenses



Any improvement was most likely due to increased contrast. Light of a short wavelength is scattered more than long wavelength light.⁶ The yellow UV protective lenses block light of a short wavelength, thus reducing scatter and increasing contrast. Therefore, patients with visual problems of increased scatter would be expected to demonstrate the greatest improvement.

We did not test for the duration of benefit. Subjective reports, from other patients, who have routinely used these lenses (only yellow lens-naïve patients were included in the trial) suggest that the benefit increased with duration of use. Patients who routinely use the yellow UV protective lenses state that due to the increased contrast, they squint less. This seems to be most true at dusk. These regular users note that both their eyes are less tired and driving, in particular, is less stressful with the use of yellow lenses. The small benefit might conceivably be magnified in a real world setting. Given that the lenses cost only \$10 to \$15 and can be purchased in any sporting goods store, even our small measured improvement is likely to be worthwhile.

Finally, patients were tested with "off-the-shelf" yellow lenses. To benefit patients the study was designed for their convenience and the low pur-

chase price. The color of the lenses can be chosen to maximize the desired effect. We did not test various wavelength yellow lenses. Consequently, there may be better, albeit more expensive, yellow/orange lenses which might be designed explicitly for this purpose. In summary, the use of these yellow "sunglasses" might provide some improvement in sight for diabetic patients while keeping expense to a minimum.

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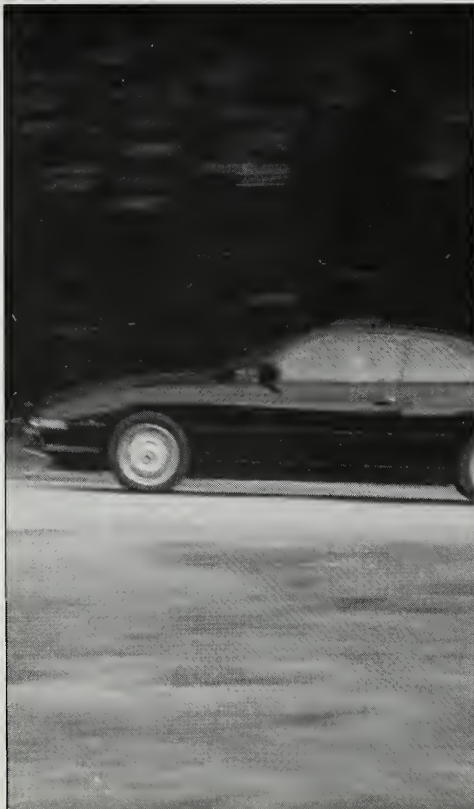
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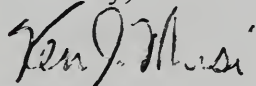
To: Medical Professional
From: Ken J. Musi
Re: Health Care Real Estate in Delaware

Within the field of medicine, physicians specialize in order to best meet the medical needs of their patients. As a commercial real estate agent, I have done likewise for equally important reasons. By becoming an expert in the field of real estate specifically suited for the Health Care industry, I have helped hundreds of physicians and medical groups acquire, sell or lease space appropriate for medical practices and health related facilities.

Since beginning my career in 1989, I have built a client base that has come to value the knowledge and expertise that I have acquired through this specialization in real estate. Many Physicians, Residential real estate agents, attorneys, accountants, and other Commercial real estate agents also recognize the importance of such a specialty, with much of my business resulting in referrals from this important professional network. Some of my clients have included: Blue Cross Blue Shield of Delaware, the duPont Hospital for Children, St Francis Hospital (Franciscan Family Care), Riverside Hospital, Christiana Care, First State Orthopaedics, The Delaware Heart Group, Gastroenterology Associates and many more. In addition, I have also assisted many physicians in finding suitable sites to develop an office building either for their business or for the purpose of investment. Whether assisting physicians just completing residency, or business managers of large practices, my real estate expertise in the Health Care field can be of tremendous value. As a member of the DMGA (Delaware Medical Group Managers Association), I remain involved in the concerns and issues facing the medical community providing an extended benefit to all of my clients.

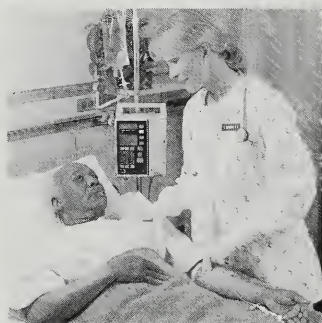
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Extremity Pain in a Child: A Case Report of Leukemia

Richard J. Bowen, M.D.
Damien Andrisani, B.A. — Kathleen Miller, B.A.

Study was completed at Alfred I. duPont Hospital for Children.

CASE REPORT

A six-year-old healthy boy presented with an inability to bear weight on his left leg due to a radiating pain over his distal tibia. The pain began when he awoke six days prior to the initial presentation and became progressively more severe. He experienced two prior episodes of pain in the lower extremity during the past five months. Each episode began spontaneously, without injury, and lasted for about six days. The left leg was involved initially, then the right. Pain was more intense at night and was sometimes severe enough to provoke periods of crying. Acetaminophen and ibuprofen provided some relief during these episodes but did not completely alleviate the pain. He was physically well and active between the painful periods.

Richard J. Bowen, M.D., is the Chairman of the Department of Orthopaedics at the Alfred I. duPont Hospital for Children in Wilmington, Delaware.

Radiographs of the right lower extremity obtained during the second episode were normal. Erythrocyte sedimentation rate was 77 mm/hr. An erythrocyte sedimentation rate repeated one week later was normal. The physical examination was normal except for exquisite tenderness and edema over the lower left leg. A full range of motion in the lower extremities was demonstrated. He has a family history of diabetes mellitus, breast cancer, basal cell cancer, and brain cancer.

Blood count revealed leukocytopenia of 4,400 with 16 percent lymphoblast cells, mild anemia with hemoglobin of 11.2, and thrombocytosis at 402,000. Erythrocyte sedimentation rate was 69 mm/hr. Radiographs of the left lower extremity showed an osteolytic lesion (Figure 1). Skeletal scintigraphy displayed eight areas of increased uptake (Figure 2). Bone marrow aspirates taken from the left tibia and from the iliac crest demonstrated acute lymphocytic leuke-

mia. Lymphoblasts expanded the marrow space, and extensive tumor necrosis was noted.

DISCUSSION

Acute lymphocytic leukemia is the most common childhood malignancy. Bone pain is the chief complaint in 18 - 33 percent of children and is reported in 21 - 59 percent.¹⁻⁷ Antalgic gait or failure to use an extremity may be the initial sign of leukemia in a child.⁸ The lower extremities are the most common locations of pain; however, the back or upper extremities may be involved.^{1,3,6} Differential diagnoses for severe, recurrent bone pain in a child include septic arthritis, osteomyelitis, juvenile rheumatoid arthritis, dermatomyositis, systemic lupus erythematosus, rheumatic fever, metastatic neuroblastoma and leukemia.^{2,6-9} Acute lymphocytic leukemia may be distinguished clinically from arthritis if pain is too intense for the suspected severity of the arthritis.⁹

Radiographic and scintigraphic findings can aid in making the diagnosis of childhood leukemia. Radiographic lesions are visible at the initial visit in 43 - 69 percent of children with leukemia, and 70 - 90 percent have irregularities during their leukemic course.^{4,6,10,11} The presence of radiologic bone involvement does not correlate with the location of pain.¹⁻⁴ Cortical changes in leukemia are non-specific and include osteopenia, lytic lesions, leukemic lines, sclerotic lesions and periosteal reaction. In children less than two years of age, these findings can be seen with many infections and nutritional states.¹¹ In children greater than two years with bone pain, these radiologic findings are also consistent with metastatic neuroblastoma and leukemia. Metastatic neu-

roblastoma usually involves the pelvis and hips, while leukemic changes are often manifested in the distal extremities.¹¹

Skeletal scintigraphy can also be helpful in diagnosing leukemia. A majority of children with acute lymphocytic leukemia have multiple bone scan lesions, most often involving the lower extremities.¹ Clausen et al performed a prospective study of 24 children with acute lymphocytic leukemia and found 19 to have increased technetium uptake in multiple sites, with the lower extremities involved in all 19. The areas of increased uptake on scintigraphy did not correlate with the clinical exam or location of radiographic lesions. In addition, of eight children with bone pain, only five had increased technetium uptake.²

Leukemic bone pain is thought to be caused by pressure from an increased volume of hematopoietic tissue in medullary cavities, haversian canals, and periosteal space.⁶⁻⁸ It has been proposed that leukemic cells from the medullary cavity may penetrate, via haversian canals, through the periosteum and the cortex of long bone shafts, thereby causing a periosteal reaction.^{7,8,10} The pressure of proliferating tissue may act directly against trabeculae or indirectly against blood vessels to cause pain and/or lytic lesions.⁷ A periosteal reaction is seen in

Figure 1. A radiograph of the left tibia that demonstrates an osteolytic metaphyseal lesion and soft-tissue thickening.



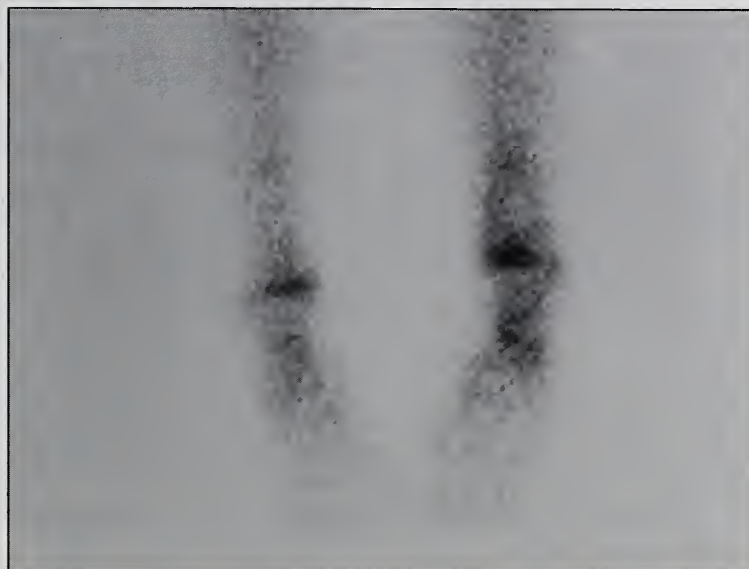
patients with leukemia and almost always occurs in conjunction with lytic lesions.^{6,10} In support of these hypotheses, leukemic patients with severe bone pain have been found to have a periosteal reaction or cortical bone lesions.^{4,12} Patients with pain who had no lesions were found radiographically to have small lesions at necropsy.⁷ Referred pain may explain the discrepancy between the location of pain and areas of increased metabolic activity detected by scintigraphy.^{1,7} Lesions adjacent to a joint have been implicated in causing the referring pain to the joint in leukemia patients when necropsy revealed joint abnormalities.^{7,8} Bone lesions may form, then stabilize. Therefore, areas of increased metabolic activity are most likely to develop a bone lesion. This may reconcile the different findings of radiographs and scintigraphy.

Radiographic changes in leukemia can be useful to monitor for remissions or relapses and to identify locations for bone marrow biopsies.^{4,7,10,12} However, the prognostic significance of radiograph findings is controversial when acute lymphocytic leukemia is diagnosed.^{4,13} A significant correlation has not been established between the presence of bone lesions and age, sex, race or cell type.^{4,11}

SUMMARY

Early clinical diagnosis of leukemia in a child is difficult. Leukemia must be considered in the differential diagnosis of extremity pain in children, especially if the "bone" pain is out of proportion to a suspected etiology. Initial laboratory studies, radiographs, and scintigraphy may be normal. Indistinct radiographic findings of periosteal reaction, osteolytic lesions, sclerotic lesions, osteopenia, or leukemic lines in a child older than two years should alert a physician to the possibility of leukemia. Clinical suspicion of leukemia should be piqued if bone scan results seem to be inconsistent with a

Figure 2. A scintigraphic scan (4.5 MCI TC99) that demonstrates increased uptake in the left tibia distally, the left calcaneus, and the left talus. Seven other lesions were seen in different bones. These included the left femur, acetabulum, ribs, maxilla and vertebral column.



suspected diagnosis or unanticipated sites of increased metabolic activity are found in the lower extremities. If leukemia is probable, a bone marrow aspiration may be needed to confirm the diagnosis.^{2,3,5,8,9}

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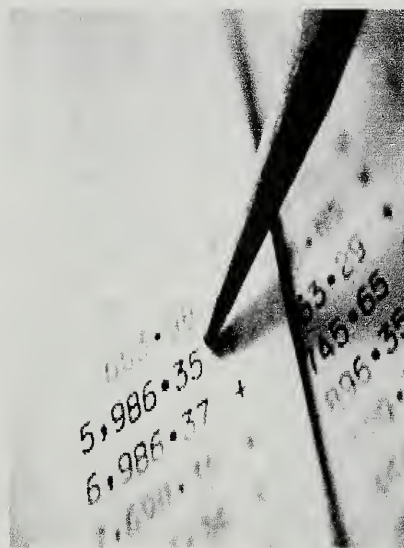
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Continuing Medical Education (CME) on the Internet

Brett Elliott, M.D.

CME on the world wide web has matured into a viable tool for the practicing physician. Pros and cons of online CME are discussed, web sites which have databases of sites offering online CME are listed, and a variety of excellent sites offering both free and fee-based CME are described.

The Internet is a basic asset for the practicing physician and one of its uses is the acquiring of continuing medical educational credits (CME) which are approved for category one status. "Online CME" has the expectation that with your Internet connection you can find out information about the CME offering, register for the course, and then study and review the material. Course information, such as articles, can generally be downloaded and saved for study or future reference. Following an examination of the course contents, most sites require that you provide comments to them by way of an evaluation form. If you want the Category 1 CME you then need to pass a multiple-choice test and at least one site requires the online submission of a short essay. Scoring of the test is generally done immediately, online, and if you pass the test you receive the CME certificate via a download, or less commonly by fax or conventional mail. Some sites charge for this service; how-

ever, a significant number do not. Generally, you need a least a 56-K modem and multimedia capability as some of the sites include sound and video. For sites that do not have multimedia courses a less robust system should work well. Connections and downloads are sometimes faster during off-hours.

When visiting the site, it should be clearly stated that the CMEs are approved for Category 1 credit and all sites reviewed in this paper satisfy this criterion. Any costs should be clearly stated, and ideally, the routine you must go through from initial registration to receiving your certificate should be clear. To register, some sites require your DEA number. Sponsorship should be obvious and proprietary issues disclosed. If a pharmaceutical company sponsors the offering, there should be a notation that their grant was unrestricted. Posting and revision dates of the module should be given so you know the information is timely. The disclosure of privacy policies is important as you will be reviewing courses and taking a test which will be graded.

Brett Elliott, M.D., is a practicing ophthalmologist and part-time JCAHO surveyor. He is a member of the West Virginia Medical Institute Board of Trustees and the Medical Society of Delaware.

Some sites subscribe to the Health On the Net Foundation Net Honor Code for Medical Websites (HON) and display the HON logo. HON at http://www.hon.ch/HONcode/Conduct_t.html is a not-for-profit organization established in 1996 with headquarters in Geneva, Switzerland. Associated with the University Hospitals of Geneva, it has among other things developed a code of ethics that medical web sites must adhere to in order to display the HON logo. The site must pledge that unless otherwise stated: medical advice will be given by qualified individuals, the information is designed to support as opposed to replace the doctor-patient relationship, confidentiality of visitors will be maintained, where appropriate there will be hypertexted links to evidence based information, the site will provide a mechanism to provide feedback from site visitors, and any commercial or advertising support will be disclosed.

There are pros and cons to net-based CME. The advantages are no travel costs, many of the CMEs are free, there is a wide selection in at least primary care, one can take the courses at any time, and you can go at your own pace. Study material usually can be downloaded as a .pdf or html file, and it can be either printed or simply saved as a computer file for future reference. For many of the sites that charge, the course material is gratis, and there is no fee until you want to receive the credits. Many CME modules have the ability to quickly explore subsidiary avenues of the topic through appropriate hypertexting. If the CME program you have started does not prove useful, it is easy to jump to another site, as opposed to traveling to a meeting which does not work out. At the end of the CME module you take the test and generally get immediate responses with respect to whether your answers were correct or not. Usually after successfully completing the test you can download your certificate and print it out if necessary.

The disadvantages are loss of direct face to face contact with colleagues. Asking questions is cumbersome and there is no immediate feedback save for the quiz at the end. Some sites have bulletin boards; however, I do not find this type of interchange as valuable and enjoyable as discussing a case with a group of colleagues. Online CME in subspecialty areas is more lim-

ited than in primary care or general medicine. It can be difficult to judge the depth of a CME site by visiting it. It is simple for anyone with a modicum of web skills to put together a sophisticated appearing site. It takes a record of accomplishment to build a well-respected medical school or hospital. When dealing with the latter you know what is standing behind the program.

FINDING CME INTERNET SITES

American College of Physicians

<http://www.acponline.org/journals/news/feb98/cme hype.htm>
Online article from the American College of Physicians *Observer* which discussed some of the pros and cons of online CME, and lists eight sites that either directly sponsor CME and/or offer the same.

Medicalmatrix

http://www.medmatrix.org/_SPages/CME_Courses_Online.asp
You need to register to access this section of the WEB site; however, there is no fee. The CME section lists approximately 40 sites. For each venue, a brief description is given and the sites are rated from one to four stars. There were three four star sites: Medscape, National Institutes of Health Consensus Statement CME Review, and the University of Florida College of Medicine.

Physician's Guide to the Internet

<http://www.physiciansguide.com/cme.html>
This site had eight hypertexted options along with a brief description of the offerings.

Search CME

<http://www.searchcme.com/search.htm>
Start by going to the "Continent/Other" window on the search menu and choose the Online-Internet option and you will get a listing of 18 sites. There is the course title and sponsoring organization; however, to learn more about the offering you have to visit the site.

SITES OFFERING AT LEAST SOME CME CERTIFICATES AT NO CHARGE

Center for Disease Control

<http://www2.cdc.gov/cep/default.htm>
This CME program is based on articles in the Center for Disease Control *Morbidity and Mortality Weekly Report (MMWR)*, and there are currently eight modules available for credit. There is no fee for this service, and you receive up to two credits per module. Articles from the *MMWR* that form the basis for the CME modules can be downloaded in the .pdf format. After reading the article, you register, take the test, and if you pass it, the CME credit certificate can be downloaded, and printed if you need a hard copy.

CME Modules at the University of Florida College of Medicine

<http://www.medinfo.ufl.edu/cme/cme/modules.html>

Currently, this site offers five CME modules covering Geriatric Education, Health Management for Older Adults, Influenza, Post-menopausal Osteoporosis, and how to use the Internet effectively. The Internet offering is in the form of a 30-minute lecture with audio and slides. The module on influenza has hypertexting to various pertinent sites; e.g. to CDC if you want information on viral replication or to another site if you need a copy of the guidelines for flu vaccination. A minor disadvantage to this otherwise excellent site is that after completing the module you have to print out the test form and then mail it in as opposed to doing everything online. As with some other sites you receive the certificate by return mail if you passed.

MedConnect

<http://www.medconnect.com>

You need to register for this site and it offers both free and fee-based CME. Sponsorship of the free areas was obvious, and this section had ten offerings on family practice and one on neurology. The family practice section had a module on the acute abdomen, which judiciously used hypertexting. For example, when discussing a 20 month old with intussusception, there is a hypertexted multimedia discussion at the University of Virginia at <http://www.med.virginia.edu/docs/cmc/cases/intuss/case9.htm>. At the end of the module you submit an evaluation form, take a test, retake it until you do well, and then download your CME certificate and if you want a hard copy, print it out. Charges for the fee based CME is \$95 for 12 hours of credit, and there are sections on managed care and emergency medicine. A relative disadvantage of the fee-based portion of this site is that offerings go back to 1996, and as of July 1, 1999 there have not been any new releases since last December.

NIH Consensus Statement CME Review

Sponsored by the National Institutes of Health

http://text.nlm.nih.gov/nih/upload-v3/Continuing_Education/cme.html

To obtain the CME credits you review NIH Consensus Statements. Ovarian Cancer, Physical Activity and Cardiovascular Health, Cervical Cancer, Acupuncture, and Hepatitis C are examples of current offerings. This site is more difficult to use than some venues such as the CDC website because you can not download the whole consensus paper for review or study. This is to be corrected in the very near future. After reviewing the consensus statement you take an online test, and receive the CME certificate in the mail. I took one of the modules on June 5, and received the certificate July 1.

Physicians' Online

http://home.po.com/cgi-bin/pol_www/signon/signon.cgi

This site requires registration and is large and growing. For CME, there are three options. A few are free, however, most charge a fee to receive the CME certificate.

Physicians' Online Options:

Virtual Lecture Hall — Over 10,000 CME credits have been awarded since 1998. To visit the site you need to separately register and create a password account; however, you can save the password information as a cookie so you do not have to enter this information when you revisit the site. All courses are free, however most, but not all, require payment if you want to receive the CME Certificate. For each module, there is a short description and colleague assessments are available. The most recent course addition was on breast cancer and is sponsored in conjunction with the American Cancer Society.

Cleveland Clinic — First you select a topic, and then take a very brief pre-test on a hypothetical patient. You are then requested to answer demographic questions, review the learning objectives, and study the course material, which is generally based on a *Cleveland Clinic Journal of Medicine* article. The course information can be downloaded in the .pdf format. You then take a post-study test, and after this pay if you want the CME Certificate.

Controversies in Cardiology Series — This is somewhat similar in format to the Cleveland Clinic series, and after completing a module you have the option of receiving 1 hour of CME for \$10.

FEE-BASED SITES

Albert Einstein College of Medicine and the interMDnet Corporation

<http://www.cyberounds.com/cme>

The CME is jointly sponsored by the Albert Einstein College of Medicine and interMDnet Corporation. The annual registration fee for 50 hours of AMA Category 1 credit is \$125.00 payable to the Albert Einstein College of Medicine. Each CME program may include conferences, images, graphics, sound, and video. A self-assessment test and evaluation form is provided at the end of each "Cyberounds" presentation.

American Health Consultants and its parent company Medical Economics Company

<http://www.cmeweb.com>

The CME modules are derived from the American Health Consultants publications. They are the *Alerts in...Clinical Cardiology, Clinical Oncology, Critical Care, Infectious Disease, Neurology, Internal Medicine, OB/GYN, Alternative Medicine, and Emergency Medicine*. The *Emergency Department Legal Letter, Travel Medicine Advisor, and the Reports in...Primary Care, Emergency Medicine, Pediatric Emergency Medicine, and Pediatric & Adolescent Medicine* are also utilized. Generally, the online and hard copy tests are similar, so if you received CME credit from one of the publication versions you will not receive credit for the online version. Each 1.5-hour unit is \$15, and there is

a rate of \$100 for 15 hours. You register, review the materials, take an online test, and receive feedback and credit immediately. There is a short, free sample module to try.

MedScape

<http://www.medscape.com/Home/Topics/PrimaryCare/PrimaryCare.html>

The MedScape home page offers a short listing of timely CME offerings. You can also use this page to find other web sites that have online CME. To locate these sites, type in the bollerian expression: Continuing Medical Education AND web in the opening menu search box and you will find a list of offerings. The most useful citation is *Continuing Medical Education on the Web, Part II* that lists eight sites and has a paragraph describing each one. You can also visit the MedScape CME center. You can get there from the opening MedScape menu or go directly VIA <http://cmecenter.medscape.com/Home/CMEcenter/CMECenter.html>

You need to initially register, and once there, you have the option of either fee-based offerings or free modules. Generally, there is a charge for most of the CME Category 1 offerings. The courses are derived from a variety of sources including electronic journals, organizations such as American Diabetic Association, and pharmaceutical company sponsored tutorials. One can search for specific topics, or browse through the CME database that contains over 250 listings. If you select the fee-based offerings, there is an annual charge of \$50 for unlimited use of the modules. This is considerably less than what most sites charge. For all the modules you can download course materials at no cost, and for the fee-based ones you receive your certificate online.

Virtual Hospital at University of Iowa

<http://www.vh.org/Providers/CME/CMEHome.html>

The most extensive offering at this site is a 20-hour CME course to satisfy CLIA requirements for physicians who want to operate a laboratory. Also, there are CME modules on adult critical care issues, pulmonary function tests, etc. Courses are supplemented as appropriate with clinical photos, pathology slides, and spirometry plots. One can take the courses gratis, and download the printed and graphic information; however, there is a charge for the CME certificate.

The variety of quality online CME currently available covers all of the common areas of medicine. Over the next several years, the percentage of CME that physicians obtain online will increase; however, it should never totally replace the attendance at meetings. The direct face to face communication and ability to easily exchange ideas that is possible at a conference can not be completely replaced by a web site no matter how technologically savvy it may be. In the final analysis, online and conventional CME are quite similar. Both are valuable tools as long as you make a judicious decision regarding which courses to study and then take them with the desire to make it an educational experience.

CME Sites on the Web

Albert Einstein College of Medicine and the interMDnet Corporation
<http://www.cyberounds.com/cme>

American College of Physicians
<http://www.acponline.org/journals/news/feb98/cmehype.htm>

American Health Consultants and its parent company Medical Economics Company
<http://www.cmeweb.com>

Center for Disease Control
<http://www2.cdc.gov/cep/default.htm>

Health On the Net Foundation (HON)
http://www.hon.ch/HONcode/Conduct_t.html

MedConnect
<http://www.medconnect.com>

Medicalmatrix
http://www.medmatrix.org/_SPages/CME_Courses_Online.asp

MedScape
• <http://www.medscape.com/Home/Topics/PrimaryCare/PrimaryCare.html>
• <http://cmecenter.medscape.com/Home/CMEcenter/CMECenter.html>

NIH Consensus Statement CME Review
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University of Florida College of Medicine CME Modules
<http://www.medinfo.ufl.edu/cme/cme/modules.html>

University of Virginia:
<http://www.med.virginia.edu/docs/cmc/cases/intuss/case9.htm>

Virtual Hospital at University of Iowa
<http://www.vh.org/Providers/CME/CMEHome.html>

Prostate Cancer Screening: What Have We Learned?

Michael R. Zaragoza, M.D.

Prostate cancer has become a significant health care concern in this country, affecting approximately one out of six men. In 1998, an estimated 184,500 new cases and 39,200 deaths were attributed to the disease.¹ It is the most common cancer in men and the second leading cause of cancer death. And yet, controversy continues over the need for early detection and subsequent treatment of prostate cancer.

For a screening program to be effective, it must provide testing of asymptomatic patients that will ultimately result in a decreased cancer-specific mortality rate. Current screening recommendations for prostate cancer endorsed by the American Cancer Society and the American Urological Association include an annual digital rectal exam (DRE) and PSA beginning at age 50 (or age 40 if

African American or positive family history). However, the US Preventive Services Task Force² and the Association of Primary Care Physicians do not recommend such routine screening.

Let's look at what we know about prostate cancer screening to date. With the advent of widespread PSA testing in the late 1980s, the mean age at diagnosis has decreased from 74 years in 1984 to 65 years in 1998. Routine testing with DRE and PSA has resulted in an increased detection rate of prostate cancer, peaking in 1996 and now tapering to a steady state.³ A higher percentage of early stage cancer is being diagnosed, thus increasing the likelihood of cure. Tumors detected by PSA screening are twice as likely to be organ-confined (70-86 percent) as those detected by rectal exam alone (30-35 percent).⁴

Opponents of screening argue that although the detection rate is increasing, we aren't necessarily finding more clinically significant disease. Focal

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microscopic prostate cancer has been demonstrated at autopsy in 75 percent of men over the age of 70.⁵ Yet only eight percent of men will develop clinically significant cancer and only three percent will actually die of the disease.⁵ This discrepancy raises the concern that clinically unimportant prostate cancer is being diagnosed, leading to subsequent overtreatment. Current data suggests otherwise. A large, multicenter study of over 6,000 men showed that 93 percent of cancer detected by current methods was clinically significant in volume (>0.5 cm²) and grade (Gleason's score >5) and thus likely to progress.⁴

Another criticism of PSA is its lack of specificity with a high rate of false positive elevations due to noncancerous conditions such as benign hypertrophy, prostatitis, and prostate stones. The sensitivity of PSA is likewise suboptimal as approximately 20 percent of prostate cancers will remain undetected at the commonly used cut-off level of 4.0 ng/ml. Yet PSA sensitivity improves greatly when combined with DRE. With a normal PSA and rectal exam, a patient's chance of having prostate cancer is only two percent. The introduction of age-specific PSA by Oesterling et al⁶ may be even more helpful in the screening process by accounting for the age-dependent increase of PSA secretion. The use of age-specific reference ranges will increase the sensitivity in men younger than 60 and increase the specificity in men older than 60 years of age.⁷

When compared to mammography for breast cancer, PSA screening for prostate cancer results in a higher percentage of organ-confined disease (75 percent vs. 50 percent) and a lesser incidence of lymph node involvement (2-3 percent vs. 20 percent). In fact, the positive predictive value of PSA screening (31 percent) is more than double that of mammography, a widely accepted screening modality for breast cancer.³ Importantly, mammography has been shown to decrease disease-specific mortality. The death rate for prostate cancer has declined by 6.3 percent from 1991-1995⁸ and continues to decrease, but the impact of PSA-based

screening has yet to be documented by a randomized, prospective trial using cancer-specific mortality as an endpoint. Such a study has been recently initiated in this country and in Europe but meaningful results won't be available for several more years.

So what have we learned about prostate screening? Using DRE and PSA as screening tools, prostate cancer has been detected in greater numbers, at earlier stages and earlier ages. Most tumors discovered are indeed clinically significant. Recent trends suggest an increase in disease-specific survival. Based on the data thus far, a compelling argument can be made for screening men between the ages of 50 and 75 who are otherwise in good health. Although prostate screening is likely to benefit society, this can only be validated when a large randomized, prospective trial has been completed.

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**The Greatest Benefit to Mankind,
A Medical History of Humanity**

(Roy Porter - WW Norton, NY and London, 1997 - 831 pp. - \$35)

David Platt, M.D.

Roy Porter is British, a professor of the social history of medicine at The Wellcome Institute for History of Science. His book reviews how medicine fits in with the social history of our civilization. It portrays at once the culture and science of medicine. It emphasizes that even as medicine has become more scientific as the centuries sped by, it has always been and will remain a part of the fabric of our culture.

This story starts with the nomadic hunters and gatherers of The Ice Age, which ended about 12,000 years ago. In moving packs, men hunted the elusive game, which was never enough to support an increase of their population. Then man was forced to adapt to agriculture. Close exposure to farm animals exposed them to the

pathogens of the animals, whence came recurrent epidemics, such as plague, smallpox, measles, typhus, and syphilis.

The story continues through the Greco-Roman period when medicine's belief in malevolent spirits, divine interventions, and miasma gave way to a natural basis for disease and healing. Greek medicine emphasized correlation between a healthy human body and the harmonies of nature. The contributions of India and China are reviewed. Then comes the blazing review of scientific progress from Pasteur to penicillin, with antiseptics, anesthesia, and breathtaking developments in surgery and organ transplantation. Scientific sanitation brought epidemics under control, and the modern era began. Life expectancy increased from 40 to 79 years. Infant death dropped 80 percent, and deaths from infectious disease 50 percent. Yet, when medicine became complacent, AIDS and the ebola virus

David Platt, M.D., is a member of the Medical Society of Delaware and is a contributing author to the Delaware Medical Journal.

appeared and became difficult to control, despite the availability of an enormous pharmacopeia.

There are chapters on tropical medicine, psychiatry, medical research, and medicine-the-people-the state-and society.

This book is good reading throughout. It will be a good choice for a cold night by the fireplace.

The author's final paragraph summarizes his frustration and sense of incomplete accomplishment for medicine:

"The close of my history thus suggests that medicine's finest hour is the dawn of its dilemmas. For centuries medicine was impotent and thus unproblematic. From the Greeks to the First World War, its tasks were simple: to grapple with lethal diseases and gross disabilities, to ensure live births and manage pain. It performed these with meagre success. Today, with 'mission accomplished,' its triumphs are dissolving in disorientation. Medicine has led to inflated expectations, which the public eagerly swallowed. Yet as those expectations become unlimited, they are unfulfillable: medicine will have to redefine its limits even as it extends its capacities."

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On The Cover

**Howard Pyle - The Mermaid
c. 1910**

Howard Pyle left this painting in his Wilmington studio when he sailed for Italy in November of 1910. Since it was on his easel, he was probably working on it in the weeks before his departure and some of his students said, after his death, that Pyle did not consider the picture finished. But there is no reference to the picture in Pyle's notes or letters or those of his students, so we have no external evidence about The Mermaid or Pyle's intentions in painting it. Apparently, it was not a commission for publication but rather an easel painting for himself. After Pyle's death in Italy, Frank Schoonover, a Pyle student and an accomplished illustrator in his own right, saw fit to paint in the three fishes and the crab in the foreground, thereby adding an unfortunate pedestrian note to a work otherwise distinguished by mysterious characters and strangely-lit seas.

The Mermaid is a beautiful and frustrating painting. It may well point to different stylistic and psychological directions cut short by the artist's early death at the age of 58. More than any other work by Howard Pyle, it allows us to bring our own feelings - aesthetic and emotional - to it. Until further discoveries about its meaning become clear - and then, perhaps, in spite of them - our own responses are the best.

UPDATE ON CRAIG SHERGOLD

An unauthorized chain letter encouraging people to send business cards to a seriously ill boy continues to generate thousands of pieces of mail each day, even though the boy is now healed and the family has requested an end to the mail.

News reports stated in 1989 that Craig Shergold, a 9-year-old English boy diagnosed with a terminal brain tumor, wanted to be recorded in the *Guinness Book of World Records* for receiving the most greeting cards. His wish was fulfilled in 1990 after receiving 16 million cards.

Shergold's tumor was successfully removed in March 1991. However, the cards and letters continue. Several versions of the letter exist, most of which wrongly claim that the young boy remains terminally ill and now wants to receive the largest number of business cards. The addressee is encouraged to gather business cards, forward them to an incorrect address in Georgia, and then forward the chain letter to ten friends.

According to President and CEO of the Make-A-Wish Foundation of America, Paula Van Ness, "Our organization is not, and has never been, associated with the letter. Yet our office continues to receive numerous phone calls each month about the letter, diverting our staff time and resources from our mission. The Make-A-Wish Foundation requests that people please stop sending business cards or greeting cards to Craig Shergold."

The Make-A-Wish Foundation of America has set up a special 800 number to explain the situation. Callers can listen to a pre-recorded message by dialing (800) 215-1333, Extension 5184.

LEAN PORK IS COMING TO TOWN

Smithfield Lean Generation, the first brand of fresh pork to be certified by the American Heart Association, will be in Wilmington Pathmark grocery stores this summer. This premier brand features more than 30 cuts of pork which meet the American Heart Association food criteria for saturated fat and cholesterol for healthy people over age two.

RE-ENGINEERING THE MEDICATION USE SYSTEM

This national interprofessional conference will be held in Baltimore, MD, from September 30 - October 3, 1999. The conference goals are as follows:

- to describe and effectively publicize the extent of preventable morbidity, mortality, and excess costs of care resulting from sub-optimal medication use;
- to stimulate enhanced discussion among health policy makers, the public, and others concerning the significant social and economic impact of medication use system disfunction;
- to develop one or more models of a re-engineering system for medication use that optimizes the clinical, economic, and humanistic outcomes from medication use;
- to identify specific national, regional, and local strategies that may be used to evaluate and implement the model(s) developed;
- to foster greater interprofessional collaboration, shared commitment to, and sense of responsibility for optimal medication use, maximizing each profession's contribution to that outcome.

Please call Max Ray, Conference Director, at 909-469-5581 for more information.

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INFORMATION FOR ADVERTISERS

The *Delaware Medical Journal* is a monthly publication of the Medical Society of Delaware. The *Journal* reaches approximately 80 percent of the state's physicians, as well as medical libraries, and hospitals; its circulation is approximately 1,700.

Full-, half- and quarter-page advertisements are accepted. Half- and quarter-page ads may be either vertical or horizontal. The *Journal* can provide such services as four-color or matched color ads; camera work (halftones, line shots); and typesetting. (See Below)

Closing for space reservations is the first of the month, two months prior to publication. Closing for materials is the first of the month, one month prior to publication.

All advertisements are subject to approval by the Publications Committee of the Medical Society of Delaware.

For a media kit or for more information, call Kristine Riccardino at 302-658-7596 or 800-348-6800 (Kent or Sussex Counties).

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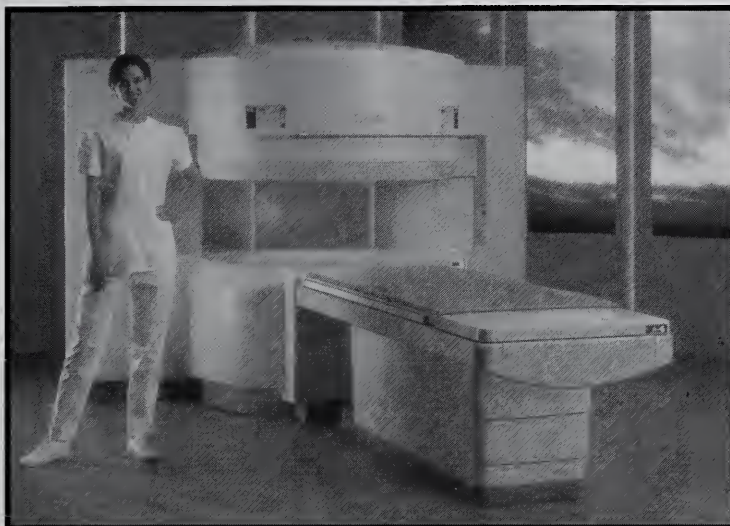
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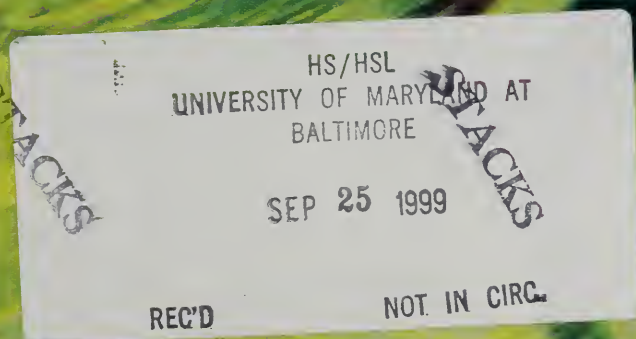
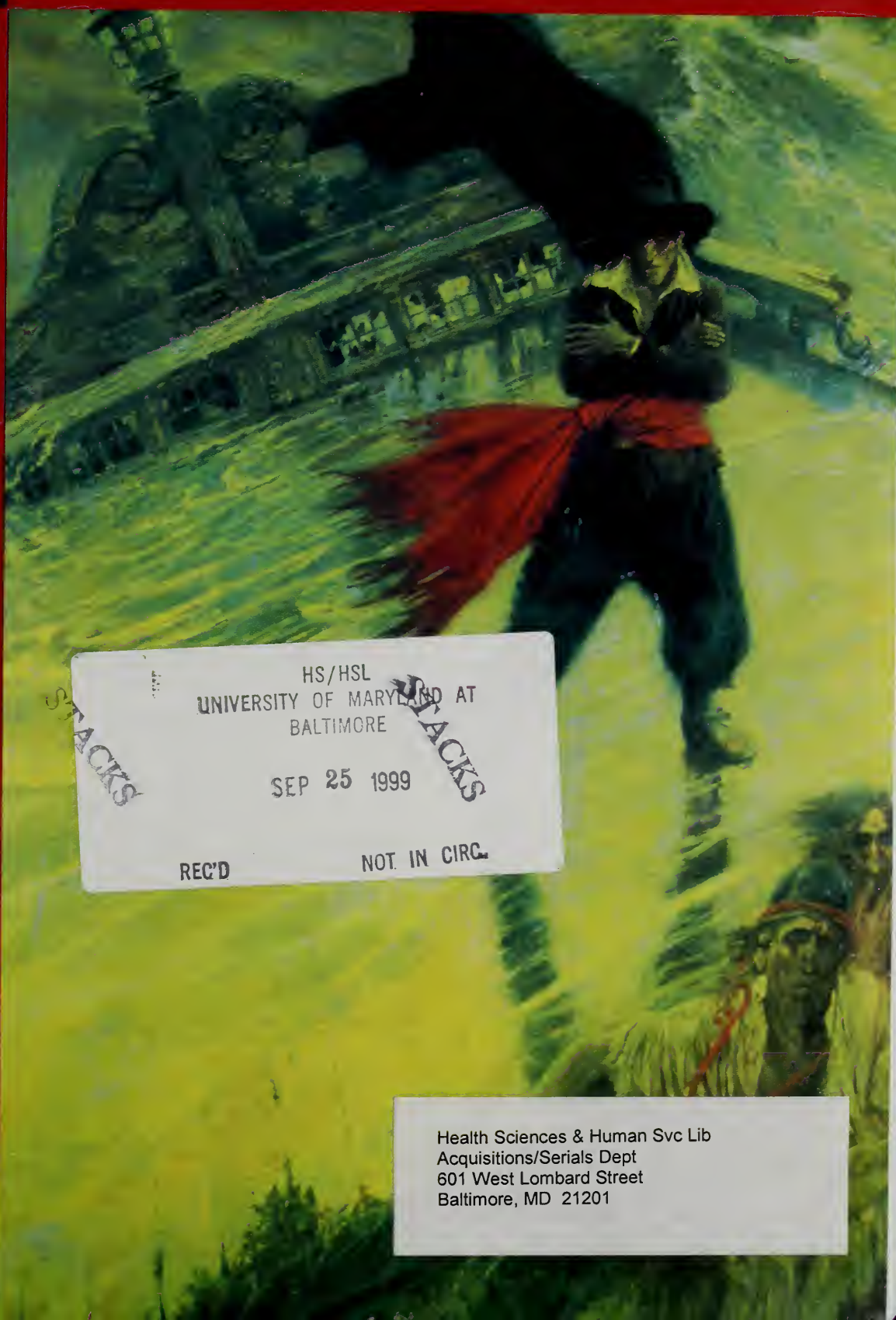
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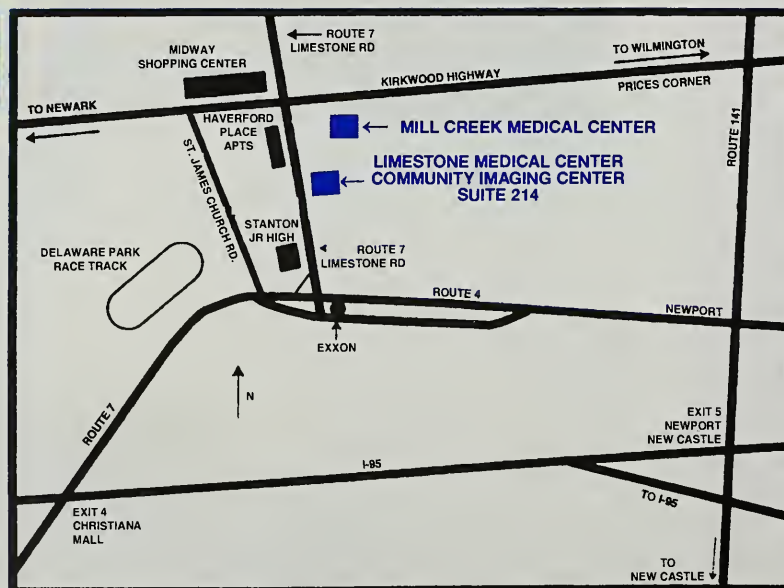
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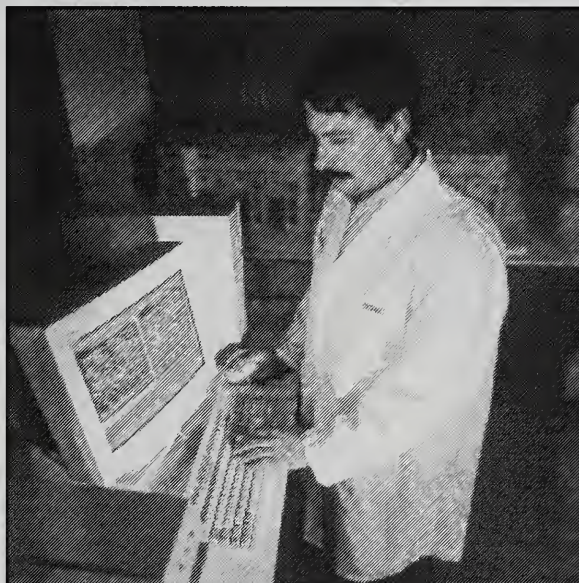
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Graphs, charts and black-and-white glossy photographs are accepted if important to the understanding of the text, but should not exceed four or five pieces. Each should have a label affixed on its back indicating its name, number, and "top." A separate legend should be provided for each. Do not write on the back, or scratch or mar them using paper clips. Do not mount them on cardboard.

Photos of patients should generally be taken in a way that obscures the patient's identity. Photos in which a patient's face must be clearly seen, however, must be accompanied by signed release forms.

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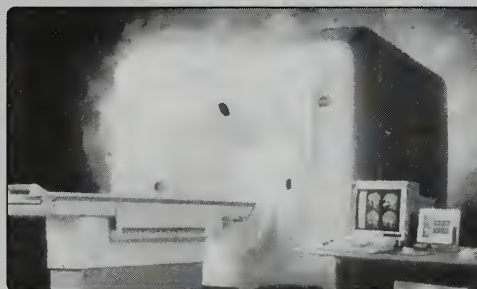
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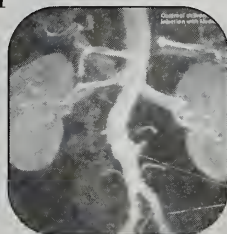
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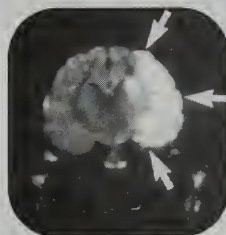
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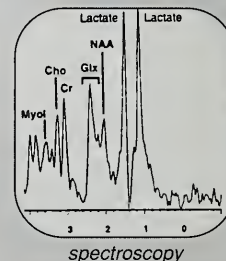
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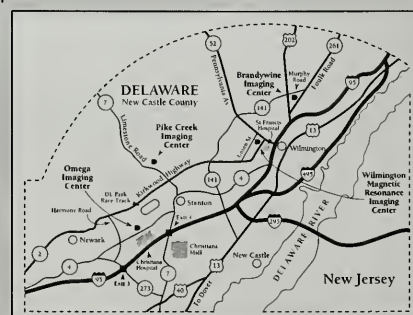
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On the Cover: The Flying Dutchman ... Painted by Howard Pyle in 1902 and displayed in the Delaware Art Museum. Our thanks to the Delaware Art Museum for allowing us to use the painting on our cover. For more information on the painting please turn to page 325.



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Politics, Statesmanship and Medicine

Martin G. Begley, M.D.



If, as it has been said, "Politics requires unrelenting combat," let me suggest that statesmanship requires unrelenting communication and good will, and it can be practiced by citizens as well as office holders.

MSD officers and other members regularly practice statesmanship, working with elected officials to secure legislation that will help patients. However, Dr. Ray Sukumar, MSD Board of Trustees member and Director of Pathology at Beebe Medical Center, has been showing us a new way to be physician-statesmen. He has invited our elected officials and their staffs to discuss health care issues in his laboratory, "where they can see the view from the trenches." In one such meeting on August 24, our U.S. Representative, Mike Castle, and some of his staff joined Dr. Sukumar, other Beebe physicians, administrators, nurses and technologists* and MSD officers and directors. A town meeting

followed to give members of the public their opportunity to discuss health care issues with Mr. Castle. It was a unique event offering each party an opportunity to get a clearer understanding of the others' concerns and needs.

Dr. Sukumar's goal, amplified by the others present, was to show how cost, not quality, of care has been the focus of HMO and Medicare driven medicine and how this approach may deprive patients of the best care while, ironically, often increasing costs. Using the Pap smear as a metaphor, he described how his lab, equipped with the latest and best thin-prep technology, is in a position to give responsive, high-quality, and timely exams for patients in the Beebe referral area. Yet, insurers mandate that most of these Pap smears be sent to other labs. There, the Paps are often not examined with the better thin prep method unless the patient pays fees above those charged at Beebe. Additionally, the Pap interpretations are often subcontracted to multiple labs. The physicians receive reports from individuals whom they don't know, whose credentials are not locally

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, DE. He is the president of the Medical Society of Delaware.

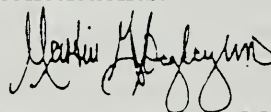
verified, and with whom they have no trusting working relationship. Often physicians want clarification of interpretations or comparison with previous Paps. Since the slides have been sent to a series of subcontracting labs, they may not be available for review or comparison with previous smears and correlation with findings from biopsies, if done. When inconsistent and uncorrelated results are obtained, patients may undergo biopsies and other procedures unnecessarily; however, situations like this could be avoided with the continuity of consultation available when using one lab. Dr. Sukumar was joined in the description of these problems by the other physicians who also emphasized that the Pap smear was just one example of misguided management by insurers' and Medicare's intrusions into patient care; many others exist throughout the range of diagnostic and therapeutic medicine.

The hospital administrators could also give examples of waste created by Medicare rules ostensibly created to contain cost. One of these is Medicare's refusal to pay for administration of some antibiotics in the outpatient setting. Patients needing these medications must remain hospitalized to receive them. This causes patient discomfort and consumes resources that could be better used elsewhere or conserved. Additionally, hospitals throughout the state are now crowded with patients who were admitted from nursing homes but are not accepted back because the low Medicare reimbursement rates, created by the Balanced Budget Act of 1997, make it financially impossible for the homes to continue to care for them. During the town meeting, a nursing home administrator noted that proof of the financial difficulties nursing homes face could be found in the grim analysts' projections and plummeting stock values of the major national elder care corporations. These facilities will soon be hit with a new round of BBA scheduled cuts and hospitals will be left bearing an even bigger burden.

Dr. Sukumar, ever fair and gracious as host, asked Mr. Castle to give his view from the vantage point of a Congressman. Mr. Castle expressed his appreciation for the Beebe staff presentations remarking that he was not aware of the situations they described. He added they

were helping him sharpen his understanding in anticipation of an upcoming major debate on health care in Congress. He then vividly described the challenge he and his colleagues face as lawmakers. Each member of the Congress or Senate has to develop knowledge and understanding of multiple major issues — defense, economy, education, crime, health care, etcetera — each of essential importance to the nation and of extreme complexity. The average office holder is always simultaneously scaling steep, continually changing learning curves on these and other issues. He also described how hard it is to move ideas through and achieve consensus in Congress of over five hundred individuals each with varying knowledge, experience and interest in each of the issues. Mr. Castle then emphasized the importance of knowledgeable citizen input in preventing the passage of counterproductive legislation.

The message from the Beebe meeting is clear: Government will continue to be an integral player in health care. We physicians, who have mastered the knowledge and skills of our very complex profession, need to join in new ways to communicate this knowledge to our elected representatives and the public. Also, physicians, who are used to and required to act promptly and decisively in medical practice, must find new determination to persevere when working with the protracted legislative process. Finally, we can expect better government policy only if more of us individually and collectively communicate to our legislators the needs of our patients, their constituents.



Martin G. Begley, M.D.
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**In addition to Dr. Sukumar, I wish to recognize the following from Beebe Medical Center:*

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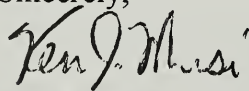
To: Medical Professional
From: Ken J. Musi
Re: Health Care Real Estate in Delaware

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Nobody Knows How Dry I Am

Peter V. Rocca, M.D., F.A.C.P.

What a summer this has been. The incessant rains of this past winter were sorely missed every time I drew back the curtains in the morning only to see a dry, brown lawn. Some mornings, I thought for sure I saw a tumbleweed or two blowing across my property. But are the problems resulting from drought only esthetic? Obviously, there are far more important concerns than a brown lawn. Economic as well as health issues are the important ramifications of extreme weather conditions although in this wealthy country of ours, the health problems bear less impact than in the third world.

Recent reports of the links between El Niño and a range of impacts on health have underscored the sensitivity of several human diseases to climatic factors. Although El Niño finds its origins in the

Pacific Ocean, scientists have long established strong secondary climatic effects on continents as far away as Africa, South Asia, and North and South America. In southeast Africa, an outbreak of cholera in Mozambique occurred last year as a result of the drought brought on by El Niño. In addition, there is evidence that malaria is increasing in incidence in a number of highland regions, for example in Kenya, which is compatible with global warming although other ecological factors may be involved as well.

Since 1976, Pacific Ocean temperature anomalies and extreme weather events have become more frequent, more intense, and have persisted longer than at any time since 1877, when records were first kept. The National Climatic Data Center records (our nation's main repository for meteorological data) indicate that extreme weather events have increased in this century in the continental United States; droughts have become longer and bursts of precipitation more "intense" (defined as

Peter V. Rocca, M.D., is an Associate Editor of the Delaware Medical Journal. Dr. Rocca practices rheumatology in Wilmington, Delaware.

more than two inches in a 24-hour period). Warmer temperatures tend to lower atmospheric pressure and pull in stronger winds, creating more extreme weather. Ocean surfaces have warmed, and the deep ocean may be the long-term repository of this century's warming.

Extreme events, viz. floods, storms, droughts, and uncontrollable fires, can be devastating for agriculture, for human settlements, and for human health. Both heat waves and winter storms bring an increase in cardiac deaths. Prolonged droughts, interrupted by heavy rains, favor population explosions of insects and rodents. The upsurge of rodents in the U.S. southwest in early 1998 warrants vigilance for hantavirus pulmonary syndrome.

Experts at the Pan American Health Organization caution that floods and drought linked to the El Niño phenomenon will have an impact on health, including increases in communicable diseases, shortages of drinking water supplies, and reduced agriculture and fish production resulting in less food, higher pollution levels, and more disasters. In areas of drought, the lack of rain increases contaminants in the atmosphere, leading to higher rates of sometimes fatal respiratory infections, which are especially dangerous for infants and the elderly. During the 1982-83 El Niño, the most severe thus far of the 20th century, North America experienced wildly unusual

weather. Australia experienced massive drought and devastating brushfires. Drought in Africa broke records, and the total damages were put at between \$8 billion and \$13 billion, with more than 2,000 lives lost.

Overseas from the US, droughts can have serious health consequences. A 1993 Norwegian study of drought-prone areas of southern Ethiopia found that 54.9 percent of children of an agricultural population had stunted growth as compared to 19.5 percent of children living in a pastoral region. Furthermore, nutritional recovery following the prolonged drought among the agricultural children was slow and associated with familial wealth.

The Chinese reported in 1997 that in parts of China there was a 7.7 percent increase in the incidence of infectious diseases and a 14.9 percent increase in mortality following a drought. Increases in cases of hepatitis, typhoid, dysentery, and "snail fever", or schistosomiasis, were cited in particular.

To those of us in this country, a drought most often means brown lawns, higher produce prices at the Acme, or, in the instance of farmers, subsidies arriving from Washington. To those unfortunate masses living in the third world, it is more a harbinger of infection, delayed growth, and, at times, death.

Doctors! A Call to Arms!

Edmund N. Carpenter, II

The views expressed by Mr. Carpenter in this editorial are not intended to represent the views of the Delaware Medical Journal nor its publisher, the Medical Society of Delaware.

The AMA's policy regarding this issue can be found in the AMA Policy Statement on Cannabis (Marijuana) H-95.998.

This is intended as a blaring trumpet, summoning members of the medical profession to fight in a war which our country is tragically losing. We need the expertise, the advice, and the leadership of doctors to solve a problem which they are equipped to understand and to combat far better than most of us.

No, I am not speaking of the apparently concluded war in Kosovo, but of the War on Drugs. Both wars are tremendously important, but by any measure, the War on Drugs, the Shadow War, is more important to us: more American lives have been and are being lost in that war; more American families are being destroyed in that war; it is more expensive, current esti-

mates being that we are spending about \$17 billion each year in an entirely futile and misguided effort to prevent drugs from coming into this country or being distributed here. So let's focus on that Shadow War today.

Why do I say we are losing the drug war? Recent federal reports indicate that drug use among teens has doubled since 1992. According to the latest study from the University of Michigan's Institute for Social Research, one in four students have used illicit drugs before reaching high school; among 8th graders, 13 percent say they have smoked marijuana in the last year - double the rate in 1991; and over 40 percent of all 10th graders and nearly 50 percent of all 12th graders have used some illicit drug. So much for the success of our \$17 billion per year program.

The drug problem has two distinct catastrophic effects on American society. First, there is the horror of addiction, and the suffering of those who negligently or deliberately, or perhaps

Edmund N. Carpenter, II, is a retired attorney. He was formerly a partner and past president of the Delaware law firm of Richards, Layton & Finger, and he is a past president of the Delaware State Bar Association and of the American Judicature Society, a Chicago based judicial reform organization. He was a member of the House of Delegates of the American Bar Association.

through the fault of parents, become addicted, and we must do what we can for them. But even more serious is the fact that by making possession and distribution of drugs criminal offenses, we have created and encouraged to grow an enormous, dangerous underworld which is profiting from the drug trade, threatening our country, filling our jails, and killing our citizens, including small children caught in the cross fire as drug criminals battle in our streets. Little Wilmington is suffering about 100 street shootings a year, many apparently arising from drug disputes.

How can we correct this situation? As to the addicts, Michael Massing in his brilliant book, *The Fix*, advocates that we return to the much more successful policy of the Nixon years and expand our treatment centers so that any addict seeking treatment can find it quickly, which is not the case today.

But as to the criminal problem, the approach must be the same as the approach we took to the vast, deadly bootlegging underworld that plagued us during Prohibition early in this century: decriminalize drugs, deprive those vicious dealers of this profit center, reduce the population of our prisons. At the present time, we have nearly two million persons incarcerated in this country, the highest per capita incarceration rate in the world with the possible exception of Russia, and it is estimated that 50 percent are held for drug related offenses. Here in tiny Delaware we have about 5,500 incarcerated, a shocking number, and drugs have played a major role in expanding this population, too.

And there is a further, unintended by-product of the effect of criminalizing the sale of marijuana that should be of special interest to doctors: the denial of medicinal marijuana to those seriously ill patients who need it to alleviate pain and suffering. Surely patients should be readily permitted to use whatever medication is most effective, subject to the supervision of a physician. The use of marijuana for medical purposes has already been endorsed by groups such as the

American Public Health Association and the Federation of American Scientists. Its efficacy has been recognized in alleviating nausea and vomiting associated with cancer chemotherapy and the syndrome of AIDS, as well as for various spastic conditions, treatment of open-angle glaucoma, and even epilepsy and migraine. Yet our laws now improperly prohibit its use.

How should we go about decriminalization? I propose we start with marijuana, clearly a drug which does not kill as many persons as legal alcohol (alcoholism and drunken driving) or legal tobacco (heart disease and lung cancer). We could decriminalize it, and treat marijuana just as we treat cigarettes, with limitations on distribution to children and prohibitions on advertising. Marijuana could then be taxed, like alcohol and cigarettes, and the tax income could be used to expand drug treatment programs.

But would this start really achieve anything, you may ask? Yes! At present it is estimated that nearly 40,000 Americans are incarcerated in state and federal facilities for marijuana violations. In all, marijuana prisoners now comprise 14 percent of all state and federal drug inmates at a \$900 million annual cost to tax payers and an incalculable damage to those 40,000 human lives, prison life and a record of imprisonment being what they are. According to the Federal Bureau of Investigation's latest Uniform Crime Report, state and local police arrested approximately 700,000 Americans on marijuana charges in 1997, almost double the number of arrests recorded in 1993.

There have been 2.8 million marijuana arrests under the Clinton administration. The new FBI statistics indicate that a marijuana smoker is arrested every 45 seconds in America. Eighty-seven percent of those arrests are for simple possession only (the remaining 13 percent are for "sale/manufacture").

But who are the experts on drugs, the individuals trained to evaluate their effect on the human mind and body, the persons skilled in curing

those who have abused drugs, who can estimate the effect of decriminalization of one or more drugs? It is the doctors who are the experts, and they and their powerful organizations are the ones who should speak out now and tell us what they, in their wisdom and expertise, think we can do to stop losing and start winning this tremendously important conflict. And the time for them to speak is now, before the situation becomes even worse, before more persons are killed by addicts and dealers, before more children's lives are needlessly ruined or destroyed.

In 1936 August Vollmer, the leading authority on American policing, said this of drugs: "Re-

pression has driven this vice underground and produced the narcotic smugglers and supply agents who have grown wealthy.... Drug addiction is not a police problem; it never has and never can be solved by policemen. It is first and last a medical problem..." What a vast number of lives have been lost and what a vast sum of money has been spent in ignorance of that advice!

The time has come to correct our futile, losing war on drugs. It is time to consider decriminalization, at least as to marijuana. Let's take this first step now. This country is crying for your help and your leadership, doctors. To the front!

On the Cover

Howard Pyle - The Flying Dutchman c. 1902

The Flying Dutchman was painted at the old mill in Chadds Ford, Pennsylvania, where Howard Pyle held his summer classes. Except for his murals, it is one of his largest paintings and was published in an issue of *Collier's Weekly*. Mr. Pyle's handyman, John Weller, posed for the painting standing on a slanting cellar door which was kept wet by water carried by the summer school students. His cape was fastened to a string thrown over a tree to hold it in position. The legend of "The Flying Dutchman" has to do with a sea captain who was condemned to sail the seas forever without touching port. The painting is being considered by the U.S. Postal Service for a stamp series on American illustrators to be printed in 2002.

This painting is on display at the Delaware Art Museum where it is part of the permanent collection.

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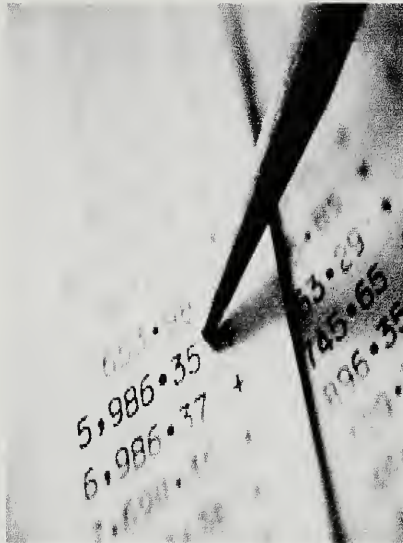
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A Moment of Silence Obituaries - 1998

E. Wayne Martz, M.D.

It is emotionally trying at times to write obituaries on my friends. At the same time it adds to my pride in the profession to review the unselfish dedication, determination and accomplishments of even the humblest colleagues. As much as possible, the Delaware Medical Journal prefers to have obituaries written by friends or family members as the deaths occur, throughout the year.

However, that doesn't always work out, and as a result of waiting for promised write-ups which never came, some of our most outstanding members in years past have gone without any recognition at all, which is in my opinion a real shame.

Of the deaths of Delaware physicians which occurred in 1998 I am aware of 11 which have not had the recognition of an obituary. Brief write-ups on them follow, alphabetically.

JOHN B. BAKER died May 5, 1998, of congestive heart failure in Milford Memorial Hospital at the age of 93. He had been a bulwark of Pediatric care in Kent and Sussex Counties for well over 50 years. Dr. Baker was a graduate of William and Mary College, and received his MD from the University of Pennsylvania in 1930. After training in Pediatrics in Philadelphia he opened his office in Milford in 1932 as the first pediatrician in that part of the state. He served in the Army during WW II with a final rank of Major, returning after the war to Milford where he became a leader in his profession and his community. His wife, Edith, predeceased him by eight years. He is survived by a son, a daughter, two grandchildren and five great grandchildren.

E. Wayne Martz, M.D., is editor emeritus of the Delaware Medical Journal.

FREDERICK A. BOWDLE died June 5, 1998, at the age of 92. He attended Penn State University and received his MD from Hahnemann in 1934. He had an office for medical practice on Franklin Street in Wilmington for over 50 years. After retirement he moved to Woodstown, New Jersey, where he lived at the time of his death. He took pride in his profession and always took care that his appearance reflected favorably on the profession, so that even well into his 80s he was often mistaken for a younger man. He is survived by his wife, Ruth, a son, a daughter, six grandchildren and two great-grandchildren.

WILLIAM J. BOYD, JR born August 5, 1937, in Nashville, died October 22, 1998, of a rapidly growing carcinoma. He was a graduate of Vanderbilt University and received his MD from Vanderbilt College of Medicine in 1966. He took his residency in Pathology at Barnes Hospital in St. Louis, one of the finest in the west. He furthered his education at Medical College of

Virginia, 1970-72. After a successful career elsewhere he came to Delaware as Medical Director of Medlab in 1988. Bill was a quiet, gentle and modest man, absolutely reliable in everything. He was a faithful participant in Medical Society committees and activities. Since he was already professionally mature when he arrived in Delaware, there was little opportunity for many of our physicians to get to know him, which is more the loss for our physician community.

ROBERT W. BUCKLEY died in retirement in Naples, Florida April 16, 1998. He was raised in Massachusetts and received his MD from Boston University School of Medicine in 1943. He trained in Psychiatry, and his career consisted of both the practice of Psychiatry and the administration of psychiatric facilities. He served in the Army in WWII, following which he worked in Cincinnati until the 1970s. He became Medical Director of Delaware State Hospital in 1976 and served in that capacity until 1983. He is survived by his wife, Dusty, three children and three grandchildren.

IRWIN FAVEL CHAVIN was born and raised in Wilmington, son of Dr. Sidney Chavin who practiced medicine there for many years and died in 1993. Favel was a distinguished graduate of the University of Delaware and Temple Medical School 1955, and took residency in Orthopedics in the Kings County Hospital in New York City. Following service in the Navy he returned to Wilmington to practice orthopedics. In the 1960s when total hip replacement became feasible he took time from his practice to study the technique in England, Switzerland and at Johns Hopkins. He brought the intricacies of this procedure back to Wilmington, the first in Delaware. Aside from his professional skills, which were outstanding, Dr. Chavin was widely known and respected for his diplomatic and administrative skills, and soon became a leader in the medical community, Medical Society of Delaware, and on the national level in the American Medical Association. He concentrated his medical activities in St. Francis Hospital where he was President of the Staff and Chairman of Orthopedics. He participated actively in relevant professional societies and his synagogue, Adas Kodesch Shel Emeth Congregation.

He died of an aggressive carcinoma on January 20, 1998, at the age 67. He is survived by his wife, Peggy, and two physician sons and two granddaughters.

V. TERRELL DAVIS died July 20, 1998, in St. Francis Hospital, Wilmington at the age of 87. He received his MD in 1936 from Washington University School of Medicine in St. Louis and joined the U.S. Public Health Service for internship and residency in Psychiatry. He early showed that rare combination of interest and talent in administrative work as well as in Psychiatry, so saw duty in many parts of the USA. After 20 years in the USPHS he left to do mental hygiene work in Wisconsin, then as New Jersey State Director of Mental Hygiene in 1957, and Professor of Psychiatry at Seton Hall/Rutgers/NJ College of Medicine and Dentistry. He fulfilled these duties in exemplary fashion, and in 1971 accepted an invitation to become Director of Psychiatry at Wilmington Medical Center and Professor of Psychiatry at Jefferson Medical College. He earned the respect and admiration of his own department and also the staff of Delaware State Hospital and Jefferson. He tried to retire in 1981, but no suitable replacement could be found. The same thing happened again in 1982, but in 1983 his replacement was finally identified and he succeeded in retiring. However he continued to play an active role in the Wilmington community and in Delaware medicine until only a few months before his death. He was survived by his wife of 22 years, Dr. Evelyn Ivey-Davis, one son, two daughters, two step-children, nine grandchildren and a great grandson. He is also survived by a former wife, Mary Watson, the mother of his children.

EVELYN P. IVEY-DAVIS was born of missionary parents in Cuba, grew up in North Carolina and Texas, died in Wilmington December 15, 1998, at the age of 84, less than five months after her husband, V. Terrell Davis, MD. She received her MD from Duke University Medical School and took her residency in Psychiatry at Johns Hopkins Medical School in Baltimore. She worked in industrial Psychiatry for a few years and a private psychiatric practice thereafter until 1965 when she pursued her main

interest in child psychiatry. She worked in pediatric mental health for the State of New Jersey until 1977 when she came to Delaware. She was a founding Fellow and Past President of the American College of Psychiatry, and for over 50 years was a member of the American Psychiatric Association. She is survived by two grown children, three step children, nine grandchildren and one great grandson. Evelyn was considered an outstanding artist, but unfortunately the full pleasure of this was denied to her and her friends in her later years by a progressive blindness.

EMERSON Y. GLEDHILL died February 19, 1998, at the age of 86. He received his MD from Columbia University College of Physicians and Surgeons in 1936, completed residency in Surgery and was certified by the American Board of Surgery in 1946. In 1952 he was named Director of the Carpenter (Cancer) Clinic of the Memorial Hospital in Wilmington, and served in that capacity the balance of his career. Information on his surviving family is not readily available to me at present.

ALDA D. HOLLIDAY died February 20, 1998 at the age of 77 in Starke, Florida. She received her MD from Indiana University in 1949, took residency at Massachusetts General Hospital and Johns Hopkins, and spent her career in Industrial Medicine in many locations throughout the world, and several in the USA, including Jacksonville, Florida, Los Angeles and Dover Air Base (which she considered home). No further information is available at this time.

ARTHUR A. MENCHER, long time Newark physician, died February 26, 1998, at the age of 93. Dr. Mencher was a 1929 graduate of McGill University Medical School, and had the distinc-

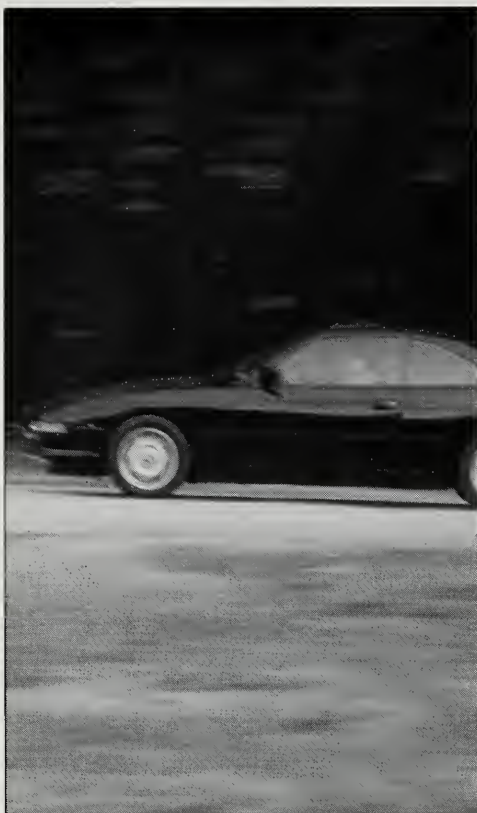
tion of being the very first intern in the Wilmington General Hospital, one of the three predecessor hospitals of the Wilmington Medical Center (Christiana Care). He entered the practice of Family Medicine in 1931 and continued until 1984. He did his own Obstetrics and was said to have delivered 2800 babies. His retirement was a major event for the community of Newark. He is survived by two daughters, six grandchildren and six great grandchildren.

ROBERT WATERHOUSE was born in Bolton, England on Christmas Day 1925. He served in the Royal British Air Force 1944-48. Following the war he pursued a career in Medicine, and received his medical degree from the University of Manchester, England, in 1954. Following three years of general practice in England he came to the USA and took internship and residency in Obstetrics-Gynecology at the Delaware Hospital in Wilmington and the Maryland Hospital for Women in Baltimore. Following certification in Obstetrics-Gynecology he practiced in Wilmington from 1962 to 1990. He held a faculty appointment at Jefferson Medical College in Philadelphia. He was Chairman of the Delaware Section of the American College of Obstetrics-Gynecology. He died at Christiana Hospital November 17, 1998. He is survived by his wife, Ruth, a son, a daughter, four stepchildren and five grandchildren

Editor's Note:

Obituaries can be found in the Delaware Medical Journal for the following physicians:

- Christos Stavros Papastavros, M.D. (Vol. 71, Issue 2)
- Stuart B. McMunn, M.D. (Vol. 71, Issue 4)



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Living Well With a Thorn in the Flesh
A Brain Priming for Healthy Life

(Sung Ho Bae, M.D. - Vantage Press, N.Y., 1998)

Thomas C. Scott, D.O.

I was asked to review this book since I profess a faith similar to Dr. Bae and must acknowledge that my opinions may be seen as biased because of this. Dr. Bae presents the theory that a healthy, harmonious and balanced life is attainable even though one might live with chronic pain, mental or physical illness.

Our present medical therapeutics seem to be built on the scientific paradigm and in this day of alternative therapeutics the author notes that Holistic care should be taken into consideration.

Thomas C. Scott, D.O., is a family practice physician at the St. Clare Medical Outreach in Wilmington, Delaware.

Dr. Bae, a neurologist, devotes much space on the neurophysiology of the brain and how we can learn to live with our infirmities that cannot be totally cured by present day medicine.

Some anecdotal information is provided by a few case histories to illustrate his concepts of victorious living in the face of chronic illness.

The book would best be understood by a reader that has a basic knowledge of the Judeo-Christian belief system.



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Is It Good Medicine? From a Staff Perspective

Mary LaJudice

I recently had the opportunity to attend the American Medical Association's 1999 Annual House of Delegates meeting, June 20 – 24, in Chicago, IL. At first, I was overwhelmed with the number of meetings that take place and the number of physicians that attend. I wondered how any hotel could accommodate such large numbers. Then, I experienced the workings of the reference committees and the House of Delegates. I stood in awe of the enormous task at hand and how well the process worked.

Whether or not to belong to the AMA has no personal meaning to me, as I am not a physician; however, this issue has been an item of discussion at the Medical Society of Delaware for the past few years. Deep down, did it really matter to me if the Society was unified or not? After

Mary LaJudice is Director of Administration at the Medical Society of Delaware.

seeing the concerns expressed by the physicians in attendance, I now cannot understand why there are some who choose not to be a member of the AMA. The great magnitude of items for discussion and the seriousness to which the Delegates and Alternates take them to heart is something to be seen. The issues debated will affect all physicians. While in Chicago, Doctors Tavani and Katz were interviewed by Delaware radio stations and discussed important issues that concern all of us. Your delegation was there representing and speaking for you.

Doctors Jim Marvel and Richard Simons were lucky enough to participate more intimately in this amazing process. Both were members of a reference committee, and Dr. Marvel had the honor of chairing Reference Committee C. I am sure they take away a wonderful experience. Being part of this process is not all fun and games, however. I saw them working into the

wee hours of the morning organizing the enormous amount of information and reporting to the House of Delegates.

The delegation should be commended for their commitment to the profession and giving up their time and being away from their families to be in Chicago. I enjoyed the opportunity and thank the Medical Society for allowing me to be part of this. I would personally like to thank the delegation for making my job a pleasant one:

Stephen Permut, M.D., Chair of the Delegation
Richard Simons, D.O. • James Marvel, M.D.
Joseph Olekszyk, D.O. • Carol Tavani, M.D.
Michael Katz, M.D. • Michael Bradley, M.D.
Kelly Eschbach, M.D. • Rafael Zaragoza, M.D.
Marshall Schwartz, M.D.

I also want to thank Mrs. Bradley and Mrs. Schwartz for their warm conversation when things got too technical.

Is it good medicine? I think it is.

Alliance Report

Llyn Balakhani, President
Medical Society of Delaware Alliance

The MSD Alliance annual meeting in May at the Dover Sheraton hosted a speaker from AMA Alliance, Chicago (National), Hope Grayson, who also performed the installation of officers.

President — Llyn Balakhani
Vice President — Kay Hosmane
Secretary — Rosalia Ford
Treasurer — Jane Henderson
President-Elect — Linda Panzer

Elaine Bradley and I attended the Annual Meeting for the AMA Alliance in Chicago. Elaine gave our state's oral report and received recognition for an award for the greatest percentage of increase in contribution to the AMA Foundation.

We had a very successful Blue Rocks Game fundraiser for DMEF. Jane Henderson calculated that we netted \$300.00 after expenses. Everyone had a great time and the fireworks were spectacular.

Our first regular board meeting will be September 16, 1999, and I hope to report more good news in the future.



Current MSD Alliance President, Llyn Balakhani (Standing), and Past-President Elaine Bradley (Seated).

Reports from the June 1999 AMA Interim Meeting

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

Submitted by Michael J. Bradley, D.O.

The following reports and resolutions were recommended for adoption.

Specialty Society Representation in the House of Delegates

The following specialty societies were granted representation in the AMA House of Delegates: American Academy of Cosmetic Surgery, American Association of Gynecologic Laparoscopists, and the American Society for Aesthetic Plastic Surgery, Inc. The American Society of Bariatric Physicians was not granted representation.

BOT(Board of Trustees) Report 33 Specialty Organization Representa- tion in the House of Delegates- Five Year Review

The Association of University Radiologists was granted one year to correct membership deficiencies. The remaining specialties under review retained their representation.

CEJA(Council on Ethical and Judi- cial Affairs) Report 1- Sale of Health Related Products from Physicians' Offices

Physicians who sell health-related products from their offices should not sell any whose claims lack scientific validity. Guidelines were established to limit the physicians' conflict of interest,

minimize the risk of brand endorsement and ensure a focus on benefits to patients. This excellent report will be the basis of a future CEJA Opinion.

CEJA Report 2- The Ethics of Human Cloning

The report discusses the issues of human cloning based on the data at present. Two potentially realistic medical uses of cloning are for assisting couples to reproduce, and for the generation of tissues when the donor is not harmed or sacrificed. Given the many unresolved issues, the medical profession should forsake human cloning at this time, and pursue alternative approaches that raise fewer ethical concerns.

CEJA Report 3- Ethical Obligations of Medical Directors

Medical directors should be bound by the AMA Code of Medical Ethics; should promote professional medical standards; should place the patients' interests above other considerations; should use fair and just criteria when making determinations; should work towards achieving access to adequate medical services.

CEJA Report 5-Patient-Physician Relationship in the Context of Work-related and Independent Medical Examinations

IMEs must disclose any conflicts of interest; maintain patient confidentiality; inform the patient about any important health information or abnormalities; and when appropriate, suggest the patient seek care for such problems.

CEJA Report 6 - Access to Medical Records by Non-Treating Medical Staff

Those not involved directly in a patient's care who wish to gain access to confidential medical information, must obtain explicit patient consent.

CC&B(Council on Constitution and Bylaws) Report 1 - AMA Medical Student Section - Speaker and Vice Speaker Reform

Changes in bylaws adopted to include the Speaker and Vice Speaker as ex-officio, non-voting members of the AMA-MSS Governing Council.

CC&B Report 2 - AMA Medical Student Section - Membership Qualifications Reform

Changes in bylaws adopted to make active membership in the AMA-MSS contingent upon enrollment in a college of medicine or osteopathy at either a LCME accredited allopathic or an AOA accredited osteopathic college.

CC&B Report 3 - Dues Delinquency Date

Make changes to the bylaws to make March 1st the dues delinquency date, starting in the year 2001.

CC&B Report 4 - Chair and Chair-Elect as Officers of the Board of Trustees

Bylaws were adopted to eliminate the Vice-Chair in lieu of a designated Chair-Elect, and make this effective in the Fall of 2000.

CC&B Report 5 - Council Reports to the House of Delegates

Adopted bylaws to provide that reports of councils be submitted directly to the House with non-binding comments from the BOT.

CC&B Report 7 - Qualifications of the Executive Vice President

Adopted bylaws to preclude any AMA Officer or Trustee from being appointed EVP for at least three years after completing a term of office.

CC&B Report 8 - Primary Spokespersons of the AMA

Adopted bylaws naming the President, President-Elect and Immediate Past-President as the Spokespersons of the AMA.

Resolution 6 - Professional Courtesy

Calls for our AMA to disseminate the AMA's and HCFA's current positions regarding professional courtesy to all physicians.

Resolution 7 - Policy for Physician Entrepreneur Activity

Calls for AMA members not to coerce patients to purchase medications, vitamins, supplements or medical devices from the physician's practice, nor to recruit patients to participate in marketing programs in which the physician personally benefits.

Resolution 9 - Addressing the Disruptive Physician

Calls for our AMA to study, and report on guidelines for managing the disruptive physician.

CC&B Report 6 - Qualification for Election as President-Elect

Adopted bylaws that prevent the Chair of the BOT from moving up directly to President-Elect without a one year spacing.

Resolution 1 - Medical Student Section and Resident and Fellow Section Representatives

Calls for our AMA to encourage and facilitate the appointment of MSS and RFS members to committees, commissions, and task forces from the BOT or House.

Resolution 4 - Physicians as Patients: Their Right to Confidentiality

Affirms that physicians who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients.

Resolution 5 - Criteria for AMA HOD Retention for Small Specialty Societies

Calls for a study on the feasibility of changing the 50% membership rules for specialty societies that fall below the 1000 member threshold, and to institute a moratorium until the study is completed and acted upon the recommendations.

Resolutions 10 & 11 - Medical Student Representation in the AMA House of Delegates

Calls for study and recommendations on creating proportionally based representation of the MSS in the HOD.

Resolution 2 - Revisiting the AMA Principles of Medical Ethics

Referred to the BOT and CEJA to reexamine the AMA Principles of Medical Ethics, a topic which CEJA is already addressing, with a report to follow at an upcoming HOD meeting.

CEJA Report 4 - Impaired Drivers and Their Physicians

Adopted the report dealing with a physician's duty of the ethical obligation to protect the public, that may in part, entail reporting patients who suffer from impairments that could limit their ability to drive safely.

Resolution 3 - Promotion and Efficient Utilization of Advance Directives

Reaffirmed current policies concerning the use of advance directives, in lieu of Resolution 3.

**REFERENCE COMMITTEE A
MEDICAL SERVICES**

Submitted by Richard P. Simons, D.O.

The following reports and/or resolutions were adopted by the House of Delegates:

Board of Trustees Report 11 - Negotiated Rule Making for Lab Tests

Summarizes the history and current status of negotiated rule making for lab tests that have been conducted by HCFA. The report recommends that the AMA reaffirm its policy to seek repeal of Section 4317 of the Balanced Budget Act of 1997 granting the secretary of HHS authority to require submission of diagnosis codes with every lab test claim.

Board of Trustees Report 19 - The Medicare Pharmaceutical Debate

Discusses the issue of adding pharmaceutical benefits to Medicare, the political popularity of such proposals, the major obstacles to

adding drug coverage to Medicare, including the lack of a clearly apparent source of funding and Medicare's financial instability, and numerous other pros and cons of the pharmaceutical benefit issue. The report recommends that current AMA policy for transforming Medicare and its long-term funding be reaffirmed and that the AMA advocate that Medicare coverage of pharmaceuticals be addressed in the broader context of transforming Medicare into a fiscally solvent program.

Board of Trustees Report 10 - Expanding Patient Choice in the Private Sector

Summarizes the key AMA advocacy, communications, and targeted outreach activities that have been undertaken during the past year in an effort to achieve the AMA's vision for reforming the private health insurance system with a particular emphasis on expanding patient choice. These activities are especially timely given the growing number of legislative proposals that seek to expand patient choice and access to health insurance through a restructuring of the tax code that would provide Americans with a tax credit to purchase health insurance. Despite these activities, further efforts are needed. The AMA must continue to place a high priority on the development and implementation of advocacy communications, coalition building initiatives, and targeted outreach activities to employers and business groups as a means of expanding patient choice in the private sector.

Council on Medical Service Report 5 - Employer Purchasing Alliances

An Evolutionary Step Towards "Voluntary Choice Cooperatives" Under Individually Selected and Owned Health Insurance: presents available comparative information on health insurance purchasing alliances that have already implemented various aspects of

individual voluntary choice cooperatives. The report also finds that existing employer purchasing alliances demonstrate the feasibility of individual voluntary choice cooperatives to address the problems of high premium costs, growth of the uninsured population, and limited choice plans.

Council on Medical Service Report 7 - Appropriate Payment Level Differences by Place and Type of Service

Summarizes the existing and proposed Medicare payment regulations for ambulatory surgical centers and hospital outpatient departments, describes relevant AMA policy and advocacy initiatives, discusses the appropriateness of payment level differences by place and type of service, and outlines the data and process necessary to conduct a comprehensive survey. The several recommendations include: encouraging HCFA to define Medicare services consistently across settings, advocating the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services, and encouraging the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology.

Resolution 128 - Insurance Coverage of Screening Examinations:

Calls for the AMA to adopt the policy that patients seeking covered screening examinations (e.g. mammograms) should be able to receive insurance reimbursement for such periodic examinations performed within an appropriately flexible interval (i.e., once annually, rather than having to wait precisely 365 days).

Council on Medical Service Report 9 - Reimbursement of Screening Bone Densitometry

Discusses the prevalence of osteoporosis, describes the current

state of bone mass measurement, including guidelines for bone mass measurement, summarizes the interim final rule that presents Medicare coverage and payment policies related to bone mass measurement, and describes relevant AMA policy and advocacy initiatives. Several recommendations are presented, including that a clinical evaluation accompany any bone mass measurement; that the patient's physician continue to participate in the diagnosis, treatment, and prevention of osteoporosis; and that private third party payers provide coverage for bone mass measurement technology and services for individuals at high risk of osteoporosis.

Council on Medical Service Report 10 – Medicare Coverage for GGTP Assays as a Part of Alcoholism Screening:

Summarizes Medicare coverage for the GGTP assay as a part of alcoholism screening, describes AMA policy related to the benefits of screening for alcohol abuse, describes the prevalence of problems associated with alcohol abuse in the United States, discusses relative value of GGTP and another assay as screening devices for alcoholism, and recommends that physicians be reminded of the pervasiveness of alcohol abuse, and benefits of early detection of alcoholism use in clinical histories or standardized screening questionnaires.

Resolution 134 – Support for an Open Medicare Coverage Process

Calls for the AMA to: 1) insure that Medicare coverage is based on the current standard of care; 2) commend HCFA on the opening up of its coverage process as described in its proposed Medicare Coverage Advisory Committee process; and 3) insure that appropriate physician input is obtained by HCFA so that Medicare beneficiaries have access to the same level of care afforded to patients outside the Medicare program.

Resolution 101 – Medicare Hospice Benefit

Calls for the AMA to seek amendment of the Medicare law to eliminate the six month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from six to twelve months as an interim measure.

Council on Medical Service Report 6 – Private Contracting by Medicare Patients

Summarizes the private contractor provision of the Balanced Budget Act (BBA) of 1997, presents current AMA policy concerning private contracting, describes the action taken to repeal the two year restriction of the provision, discusses both the rationale against unrestricted private contracting and the rationale for liberalizing private contracting, describes discrepancies in the BBA provisions language, and recommends that HCFA clarify the ambiguities of the private contracting language contained in the BBA.

Resolution 113 – Timely Distribution of Medicare Office Laboratory Fee Schedules

Calls for the AMA to work with HCFA to require that all Medicare carriers include the Laboratory Fee Schedule with the Enrollment Package and Physician Fee Schedule for Medicare Part B each year.

Resolution 115 – Payment for Complicated Care and Necessary Followup Care

Calls for the AMA to continue to advocate for appropriate reimbursement for follow-up care of complications and stage procedures from payers, including state and federal agencies.

Resolution 120 – Y2K Diagnostic Report Dates

Calls for the AMA to work to facilitate an agreement with HCFA so that Medicare will accept a date stamp initiated by technicians on all diagnostic testing reports performed by

equipment with Y2K date problems.

The following reports and/or resolutions were recommended for adoption as amended:

Council on Medical Service Report 2 – Status Report on the Uninsured

Summarizes legislative and administrative initiatives intended to decrease the number of uninsured, describes AMA policy on universal coverage and access, and discusses the characteristics of the uninsured in 1997 with suggested coverage priorities. The report also notes that access to individually owned insurance is limited by high cost in the current market, and provides several policy recommendations, including a recommendation to oppose benefit mandates unrelated to patient protection because of the impact on cost. Recommendation 3 and 4 of the report were amended by substitution to read as follows: 3) that the AMA urge HCFA to insure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in states or localities with large uninsured ethnic populations; 4) that the AMA encourage state medical associations, state specialty societies, and other physician organizations to work with appropriate state agencies to develop innovative programs to expand coverage for the uninsured.

Resolution 107 – Reimbursements for Medically Necessary Injections

Resolution 107 was amended by addition and deletion to read as follows: Resolved that our American Medical Association 1) work with the Health Care Financing Administration and with third party payers to streamline the process of obtaining reimbursement for medically appropriate injections given at the time of the visit; and 2) advocate that physicians be informed of the mechanism that HCFA has to resolve reimbursement disputes through the HCFA Fair Hearing Process.

Resolution 135 – Medical, Surgical, and Psychiatric Service Integration and Reimbursement

Calls for the AMA to: 1) advocate for health care policies that insure access to and reimbursement for integrated medical, surgical, and psychiatric care regardless of the clinical setting; 2) advocate for standards that encourage medically necessary treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients. Minor wording changes were adopted.

Resolution 106 – Timely Medicare Patient Eligibility Information

Resolution 106 was amended by addition and deletion to read as follows: Resolved that our American Medical Association strongly encourage Medicare to move immediately to provide physicians with timely Medicare patient eligibility information; and be it further resolved that our American Medical Association strongly encourage Medicare to change its entire claim processing system from a batch processing system to a real time processing system.

Resolution 140 – Credentialing of Physicians by HCFA

Substitute resolution 140 was adopted to read as follows: Resolved that our American Medical Association vigorously oppose efforts by the Health Care Financing Association to impose specific requirements for any specific area of medical practice that dictate credentialing, privileging, and continued medical education requirements which are better left to hospital medical staffs and medical licensing boards, and resolved that our AMA also vigorously oppose any efforts by HCFA to usurp the prerogative of hospital medical staffs, of medical licensing boards, or appropriate medical organizations to credential, privilege, and define continuing medical education requirements for physicians.

Resolution 118 – Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and a Provision of Adequate Insurance Coverage to Provide for Their Treatment

The adoption of substitute resolution 118 reads as follows: Resolved that our AMA support teacher education initiatives to better enable them to identify children at risk for psychiatric illnesses, substance abuse, and potentially dangerous behaviors, and be it further resolved that our AMA reaffirm its support of coverage for mental illness.

Resolution 138 – Study of Medicare Costs

The resolution was adopted, amended as follows: Resolved that the American Medical Association seek to obtain information and develop a report of total Medicare expenditures with a breakdown of total dollars as well as percent of such for the following areas: physician fees, hospital fees, durable equipment, home health, administration (with specific emphasis on administrative costs relative to pursuit/ collection of fraud and abuse), and other areas as deemed necessary.

AMA policies reaffirmed in lieu of resolutions:

Resolution 131-Patient Choice in Medicare Reform; Resolution 132-Health Care Equity in Medicare Reform; Resolution 136-Medicare's Successor: A Private Plan for Seniors

Resolution 131: cause the AMA to actively lobby the Congress of the United States for legislation providing Medicare beneficiaries with the option to purchase their own private health insurance; and that the AMA advocate the creation of an independent Medicare "benefits board," appointed by both the Administration and Congress, which would specify the detailed benefits subject by an up or down vote by Congress.

Resolution 132 calls for the AMA to study the concept of a "premium support system" as a sensible approach to needed Medicare reform, and make appropriate recommendations based on that study to the House of Delegates.

Resolution 136 calls for the AMA to appoint a committee from the AMA House to evaluate a representative sample of appropriate private sector ideas and plans for a fair, fiscally sound and viable health care plan for the senior citizens of our country, and such committee make a report of its findings to the House of Delegates at the 2000 Annual Meeting.

It was noted that these resolutions were consistent with current AMA policy regarding individually owned and selected health insurance and the AMA's goal of transforming Medicare. In particular, AMA's policies H-165.890 and H-330.968 address AMA support for the development of alternatives to Medicare.

Resolution 104 – Implementation of the States Children's Health Insurance Program

Called for the AMA to support the American Academy of Pediatrics and other organizations in advocating for the rapid and timely implementation of the states' children's health insurance program (S-CHIP) and work with other organizations to prepare suitable informational and promotional materials on the status and background of the S-CHIP and that this material be updated on a regular basis and made available through the AMA's website in conjunction with American Academy of Pediatrics to interested AMA members, medical societies, and leaders.

It is noted that numerous sections of AMA policy H-290.982 addressed the S-CHIP program, calling for states to streamline the enrollment process and strongly urging both

state associations and individual physicians to take part in educational and outreach activities aimed at CHIP eligible children.

Resolution 108 – Failure of Employer Based Health Insurance
Calls for the AMA 1) to urge federal legislators and others in Congress to give all individuals the right to purchase medical care and health insurance with pretax dollars; 2) continue to work to create alternative models for health care coverage with the goal of inclusion for all United States citizens.

It was noted that Resolution 108 is consistent with current AMA policy related to tax treatment for individually purchased coverage and creation of individually selected and owned health insurance and therefore recommended that policies H-165.920 (6) and (7) and H-165.889 be reaffirmed in lieu of Resolution 108.

Resolution 105 -Indemnity Health Insurance Study; and Resolution 133-Strategy for Individual Ownership of Health Insurance
Resolution 105 calls for the AMA to study trends and the availability and purchase of indemnity health insurance coverage in the United States, including mental illness.

Resolution 133 calls for the AMA to 1) establish a work group to develop a strategy encouraging patients to select and own their health insurance; 2) encourage the use of medical savings accounts with tax deductible contributions and consumer choice provisions such as those in the federal health benefits program being included in the development of individual selection and ownership strategy; feasibility of individually chosen, individually purchased health insurance which provides premium support for the uninsured and lower income wage earners be studied as part of the strategy of individual selection and ownership of health insurance.

It was noted these resolutions were obtained in current AMA policy H-165.920, H-385.974, and H-385.987 and explained in the current AMA advocacy document Rethinking Health Insurance.

Resolution 127 – Cost of Living Increases to Physician Fees
Calls for the AMA to seek the introduction of appropriate federal legislation calling for the levels of physician payments by public and private health insurers to be annually adjusted by the cost of living index tied to the Department of Labor cost of living index with this increase remaining independent of adjustments made by any rising costs of providing services. Existing AMA policies H-330.932, H-400.972, and H-400.965 support adequate adjustment of physician payment to account for factors related to cost of living and physician practice cost increases as well as inflation.

Resolution 139 – Universal Billing and Reporting Form
Calls for the AMA to collaborate with the American Academy of Pediatrics and other medical specialty organizations in advocating that all third party payment programs and carriers must accept the HCFA 1500 universal claim form as the standard in reporting HEDIS 3.0 performance measures.

It was noted that existing H-190.975 and H-190.993 encourage the acceptance and use of the HCFA 1500 form by federal, state, and private insurers.

The following reports and/or resolutions were deferred for decision:

Resolution 110 – Managed Care Reimbursement Formulas

Resolution 103 – Medicare Denials of Preoperative "Screening Tests"

Resolution 142 – Medicare Pilot Project

Resolution 143 – Medicare Pre-paid Competitive Demonstration Project

Resolution 112 – Medicare to Pay for Routine Physical Examinations

Resolution 116 – Payment for Clinical Preventative Services

Resolution 111- Teleconsultations and Their Reimbursement

Resolution 123 – Creation of AMA Data Bank on Interstate Practice of Medicine

REFERENCE COMMITTEE B LEGISLATION

Submitted by Michael S. Katz, M.D.

Actions taken by the AMA House of Delegates on Reference Committee B resolutions (Legislation) included Non-physician prescribing authority, public access to unpublished research data, Aetna US Health Care-Prudential Merger, National Data Bank, and Physician responsibility for nursing agencies.

Explanation of Public-Private Partnerships That Exist Between Government and the AMA

Recommends that the AMA continue to advocate HCFA adoption of AMA policy positions and continue to work cooperatively with HCFA to achieve its policy objectives. When advocacy efforts directed at HCFA fall short of achieving AMA policy objectives, the AMA should continue to seek congressional action including oversight hearings and enactment of legislation.

Veterans Administration Health System

Asks the AMA to support approaches that increase the flexibility of the Veterans Health Adminis-

tration to provide all veterans with improved access to health care services.

Bounty and Fraud and Abuse

Directs the AMA to use all available means to have HCFA immediately rescind the policy of paying a bounty to patients for reporting their physicians and that the AMA insist on a public apology from HCFA and to all physicians who are innocent of fraudulent billing and HCFA immediately cease and desist from an ongoing pattern of behavior that demeans, defames and discredits the public's perception of all decent physicians.

Aetna US Health Care-Prudential Merger

Directs the AMA to secure intervention by the Department of Justice to stop the Aetna/US Health Care merger with Prudential Insurance.

Federal Tax Legislation

Asks the AMA to advocate policy H-165.920 which supports the development of federal tax legislation which would encourage the independent purchase of health insurance by individuals and families.

Public Access to Unpublished Research Data

Asks the AMA to oppose extension of the Freedom of Information Act to require premature release of research data from federally funded research and work with other scientific and medical organizations to seek repeal of this requirement.

Non-Physician Prescribing Authority

Asks the AMA to work with state medical societies and national medical specialty societies to utilize appropriate regulatory, legislative and legal means to oppose the May 4, 1999 Federal Register published Department of Veterans Affairs proposed rule that would permit non-physician health care professionals authorized by the DVA to prescribe medications.

Disruptive Visits to Medical Offices by Government Investigators and Agents

Asks the AMA to encourage physicians to report incidents of inappropriate intrusions into their medical offices to the AMA's office of the general counsel and consider development of a hotline for implementation.

Medical Care for Persian Gulf War Veterans

Referred to the Board of Trustees for report back at A-2000; asks the AMA to support congressional establishment of a voucher-style of medical insurance options using VA's present operational funds in order to provide long-term health care for Persian Gulf War veterans and military subcontract workers with new and unexplained illnesses which presented after working in the Arabian desert between 1991 and 1996; Congressional action mandating that, at the present time, VA provide free medical care for all Persian Gulf War veterans and military subcontract workers who fell ill with any chronic illness extending over six months duration after working under U.S. government contract in the Arabian desert anytime between 1990 and 1993.

Physician Responsibility for Nursing Agencies

Referred to the Board of Trustees for report back at A-2000; asks the AMA to seek federal legislation or regulatory relief requiring that Medicare and other insurers hold nursing agencies responsible for their billing practices and for the care decisions they make that either deviate from physician instructions, are devoid of related physician input, or violate HCFA guidelines. Physicians should be held harmless when their Home Health Certification and Plan of Care forms differ from the actual services rendered by the nursing agency.

REFERENCE COMMITTEE C MEDICAL EDUCATION

Submitted by James P. Marvel, Jr., M.D.

It was my privilege, as a delegate to the American Medical Association, to be asked to serve as chairman of Reference Committee C and to present the report of Reference Committee C to the House of Delegates. The following report chronicles the actions of Reference Committee C.

As a result of the hearings of Reference Committee C, the following reports and resolutions were recommended for adoption:

Recommendations of the Board of Trustees Report 25 - Update on Development of Branch Campuses of International Medical Schools

This report included an update on the Ross Medical School establishing a branch campus in Casper, Wyoming, and asked that the AMA continue to provide information and support to the Wyoming Medical Society. It was noted that all of the United States medical schools are voluntarily accredited by the LCME, and asked that the AMA join with the Association of Medical Colleges in support of the process of voluntary accreditation of medical education programs in the United States. It was further recommended that the issue of educating the public and the profession about LCME accreditation be emphasized, along with a recommendation regarding continuing support for the Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) medical education program.

Council on Medical Education Report 7 - State Authority and Flexibility in Medical Licensure for Telemedicine (Resolution 318 I-97)

It was recommended that the AMA amend Policy 8480.969 to read, "It is a policy of the AMA that the medical boards of states and territories

should require a full and unrestricted license in the state for the practice of telemedicine, with no differentiation by specialty for physicians who wish to practice telemedicine in that state or territory. It was further recommended that the AMA develop a policy regarding the practice of medicine as it relates to the prescribing of prescription-only pharmaceuticals or other therapies by way of the Internet. In addition, the council asked the AMA to maintain its opposition to a single national federalized system of medical licensure. Specifically, it was recommended that the AMA address on an urgent basis the issues raised by prescribing prescription-only pharmaceuticals on the Internet without an adequate patient-physician relationship.

Resolution 319 – Support for Upgrading and Expanding Medical Research Facilities

This resolution asked that the AMA work with related organizations and elected officials to support efforts to fund modernization and expansion of bio-medical research facilities. There was unanimous testimony in support of this resolution and the House of Delegates adopted the resolution as recommended.

Resolution 305 – Adoption of Sexual Orientation Non-Discrimination and Gender Identity in LCME Accreditation

This resolution asked the AMA to urge the Liaison Committee on Medical Education to expand its current accreditation standard to include a non-discriminatory statement related to all aspects of medical education and to specify that the statement must address sexual orientation.

The Reference Committee heard consistent testimony in support of this resolution and a representa-

tive from the LCME expressed a willingness to consider expanding discrimination policy to include sexual orientation. This resolution was adopted by the House of Delegates.

Resolution 307 – Standardization of MCAT Exploration

It was recommended by the Reference Committee that Resolution 307 be adopted, and such was carried out, asking the AMA to work with the Association of American Medical Colleges to develop a policy regarding a standardized period for exploration of the MCAT scores, allowing for modification of the exploration period if the exam format changed significantly.

Resolution 302 – Governance of the National Resident Matching Program

It was recommended by the Reference Committee that this resolution be adopted, and such was carried out by the House of Delegates, asking the AMA to encourage the National Resident Matching Program to structure its Governance Board so as to include designated seats for direct representation of residency directors and the medical school deans of students.

Joint Report of the Council on Medical Education and Council on Scientific Affairs – Medical Education and Training in Women's Health (Resolution 308, A97)

This joint report responded to Resolution 308 (A97) and proposed a series of actions to assure that medical students, resident physicians and physicians are continually updated on information developed regarding women's health.

The House of Delegates adopted the recommendations contained in this joint report and recommended that they be adopted in lieu of Resolution 308 (A97).

Resolution 324 – Physician Workforce Planning and Physician Retraining

It was recommended by the Reference Committee that Resolution 324 be adopted and such was carried out, asking the AMA to consider physician retraining during its deliberations on physician workforce planning, and that the AMA do a survey of all USA residency programs to identify the number of physicians undergoing specialty training, in order to assess the extent of physician retraining needs, with a report to the House of Delegates by A2000.

Council on Medical Education Report 3 – Clinical Supervision of Resident Physicians by Non-Physicians (Resolution 315, A98)

This report was adopted, recommending that AMA's Principles of Graduate Medical Education be amended to include a statement that it is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and that he supervises all care rendered to the patient.

Council on Medical Education Report 4 – Training of Physicians Under Managed Care (Resolution 318, A98)

It was recommended by the Reference Committee that the recommendations in Report 4 of the Council on Medical Education be adopted in lieu of Resolution 318. The resolution recommended reaffirmation of AMA policy supporting the concept of medical education programs and teaching institutions working collaboratively with managed care organizations to develop educational opportunities for medical students and residents.

Resolution 314—Licensure of IMGs

It was recommended that recommendation A be amended to read that the AMA ask the Federation of State Medical Boards to request all the state licensing boards to adopt a uniform standard governing the allowed number of administrations of the licensure examinations.

The Reference Committee heard testimony that supported the rights and needs of state licensing boards to establish their own requirements, balanced by the benefits of having goals reflecting national uniformity. The House of Delegates adopted Resolution 314 as amended.

Council on Medical Education Report 5—Clinical Skills Assessment (CSA, Resolutions 323 and 326, A98)

It was recommended that the AMA ask the Liaison Committee on Medical Education to gather additional data on the use of CSAs and standardized patients and to emphasize the importance of adequate clinical skills assessment in the accreditation process for U.S. medical schools. The House of Delegates recommended that this report be referred to the Board of Trustees, with a report back at 199.

The second recommendation called for substitution for Recommendation 7 and Report 5 of the Council of Medical Education to read that our AMA, through its representation on the National Board of Medical Examiners, ask that the Clinical Skills Assessment not be implemented until the fiscal and geographic burdens are minimized. This recommendation was accepted by the House of Delegates.

Resolution 303—Color Blindness

The Reference Committee recommended that the House of Delegates adopt substitute Resolution 303 and such was the case, resolving that our AMA encourage

medical schools to be aware of students with color blindness and its effect on their medical studies.

Resolution 321—Preventing Negative Effects from the Balanced Budget Act on Teaching Hospital Missions

It was recommended by the Reference Committee that Resolution 321 be amended to read that our AMA continue to advocate for adequate and stable funding of medical education and research, with equivalent funding for children's hospitals. This resolution, which was ultimately adopted by the House of Delegates, asked our AMA to recognize the important mission of teaching hospitals and to work with appropriate organizations to maintain existing support for graduate medical education through Medicare until an alternate approach, such as an all-payers system, is developed.

Council on Medical Education Report 2—The Emerging Use of Hospitalists: Implications for Medical Education

The Reference Committee recommended that the recommendations in Report 2 of the Council on Medical Education be amended to read, "The use of a hospitalist physician as the physician-of-record during a hospitalization must be voluntary, and the assessment of responsibility to the hospitalist physician must be based on the consent of the patient's personal physician and the patient." The House of Delegates adopted this amended report of the Council on Medical Education.

Council on Medical Education Report 9—Principles for Graduate Medical Education

Council on Medical Education Report 9 recommended adoption of 15 principles which deal with such matters as the purpose of graduate medical education, the need for education in the broad field of medi-

cine, research as a part of residency education, institutional responsibility for graduate medical education, the compensation of residents, the appropriate length of residency education, the supervision of residents, the need of innovation in graduate medical education and the evaluation of residents.

Your Reference Committee heard strong support for adoption of the Report, with minor revisions. It was felt that all faculty involved in residency training should be engaged in scholarly activities. Parental leave was added to the designated fringe benefits to reflect the current social climate. Recommendations contained in Council on Medical Education Report 9 were adopted as amended and the remainder of the Report was filed.

Council on Medical Education Report 10—Policy Options for Support of Graduate Medical Education

As part of its review of existing AMA policy, the Council on Medical Education held an open hearing on the number of medical students in United States M.D. and D.O.-granting schools and on the number of graduate medical education positions. As a result of this hearing, the Council on Medical Education recommended the adoption of 14 principles as AMA policy, and that these 14 principles be communicated to federal and state policy makers. There were minor wording amendments to this report and the House of Delegates recommended adoption as amended. The remainder of the report was filed.

Resolution 301—Due Process for Physicians in Training

It was recommended and accepted that this resolution be re-titled, "Grievance and Appeals Process for Physicians in Training." This resolution was submitted by the Wisconsin delegation, asking the AMA and its appropriate specialty sections to study contracts for phy-

sicians in training and develop model language for due process procedures in these contracts. The feeling of the Reference Committee was that the issue to be addressed by this resolution is the grievance and appeals process and not the broader issue of due process, therefore accounting for the name change. This resolution was adopted as amended, with a change in title.

Resolution 310 – Annual Contracts for Continuing Residents

This Resolution called for the ACGME to require resident-training programs to provide the residents with notice of non-renewal of contracts no later than 4 months prior to the end of their contract. This represented a substitute resolution and was appropriately adopted by the House of Delegates.

Resolution 312 – Implementation of the AMA-ME Number

This Resolution, which was ultimately adopted as amended, was introduced by the Resident Fellow Section, asking the AMA to encourage pharmacies, insurance companies, pharmaceutical companies and state Medicaid programs to use AMA Medical Education Numbers for physician identification purposes. The Resolution also asked the AMA to expedite assigning an AMA Medical Education Number to every U.S. and international medical graduate in a United States graduate medical education program.

Resolution 315 – Medicare Support for Duration of Residency Training

This resolution was adopted as amended by the House of Delegates and was introduced by the Texas delegation, asking the AMA to 1) join with the Child Neurology Society and the American Academy of Neurology in supporting restoration of appropriate funding for train-

ing in child neurology; 2) support an enactment of a technical amendment to Medicare Direct Medical Education provisions to provide that the duration of full funding for all residents shall be the period of training in the approved program, after which the resident is eligible to become Board-certified. As part of the testimony relating to this resolution, it was noted that the current regulation for Medicare Direct Medical Education payments results in incomplete funding for residents to become eligible for Board-certification.

Resolution 320 – Attending Supervision of Night-Float Rotations

This resolution was adopted as amended by the House of Delegates and was introduced by the section of medical schools, asking our AMA to support hospitals and residency programs, including those utilizing night-float systems, continuing to assure that there is on-site availability or rapid access to appropriately qualified attending physicians for training supervision and the provision of the best quality of medical care.

Council on Medical Education Report 6 – Medicare Payments to Teaching Physicians, the Primary Care Exception (Resolution 810, A98)

The Reference Committee recommended that the AMA seek legislative initiatives with specific language to enhance the availability of teaching physicians in all specialties through fair and consistent compensation for this vital service. This recommendation was adopted by the House of Delegates. It was further resolved that the AMA support extension of the Primary Care Exception to all specialties. It was noted that the Council on Medical Education Report 6 recommended that the AMA 1) support the continuation of the "Primary Care Exception" for teaching physicians pro-

viding Part A Medicare covered services; 2) work with the Health Care Financing Administration, and congress if necessary, to modify the Primary Care Exception rule to extend to physician's offices and patient's homes the same provisions that now apply to hospital outpatient departments and ambulatory care departments when and if such sites become eligible for payments under Part A of the Medicare Trust Fund; and 3) monitor the ongoing legislative initiatives and support specific language to enhance the availability of teaching physicians through fair and consistent compensation for this vital service.

There was considerable support for this Resolution. However, it was felt that the entire issue was divisive in that the educational needs of all specialties require a graduated increase in responsibility for residents, yet only a few are granted this exception by the Health Care Financing Administration. This testimony convinced the Reference Committee that the AMA should seek every opportunity to correct this imbalance and to look for additional options to support teaching physicians.

Board of Trustees Report 15 – Diversity in Medical Education

This Board of Trustees Report reflected the views of the AMA Minority Affairs Consortium, which was established in June of 1977 to create new pathways for participating in the AMA and to assist the Association in addressing minority health disparities and the professional interests of minority physicians. Support was expressed for the report and concurrence with its conclusions. The House of Delegates voted to adopt this report as amended.

Resolution 316 – Medical Education for Members and Underserved Minority Populations

The substitute Resolution 316 was recommended by the Reference Committee and adopted by the House of Delegates, asking our AMA to actively support the enrollment of minorities in pre-medical and medical programs, to increase participation of minorities in biomedical research and to organize a national conference addressing these issues.

Council on Medical Education Report 8 – Alternatives to the Federation of State Medical Boards' Recommendations on Licensure

The Council on Medical Education Report 8 recommended adoption and dissemination to medical schools, residency programs, state licensing boards, state medical societies and other groups with responsibility for medical education, of a series of principles to guide the development of policies that protect the public by establishing qualifications for resident physicians. These recommendations are designed to provide an alternative to the recommendations on licensure issued in 1998 by the Federation of State Medical Boards.

Specific areas addressed in the testimony before the Reference Committee included the need to insure that young physicians can expeditiously obtain a license to practice medicine after residency training, the need to insure that comprehensive information on medical students be included in the Dean's Letter of Evaluation in a standardized format, and that information on medical students not be reported to state medical licensing boards.

Resolution 22 – Development of Courses to Prepare Medical Students and Residents for the Political, Legal and Socio-Economic Aspects of Practice and Physician Advocacy

This resolution was introduced by the organized medical staff section, asking that the AMA develop, in conjunction with the state medical societies, education programs on the political, legal and socio-economic aspects of medical practice and physician advocacy. These programs would be offered to medical students and resident physicians throughout the country, to supplement their clinical education and prepare them for practice. There was significant testimony that this subject matter was important and that there were gaps in current education for medical students and resident physicians. It was pointed out that local medical societies, as well as state societies, had expertise to contribute. Local and state medical societies could also provide mentorship opportunities for students and resident physicians, which would introduce them to organized medicine. This resolution was adopted as amended.

Resolution 317 – Non-educational Closing or Downsizing of Residency Programs: Responsibility to Hold Residents Harmless

This Resolution, introduced by the Ohio delegation, asked that the AMA ask the Accreditation Council for Graduate Medical Education to encourage approved residency programs that undergo downsizing or non-educational closings to seek sources to fund residency slots for all residents in good standing until the scheduled completion of the residency training or until they have started in a commensurate paid residency position.

The Reference Committee heard limited testimony on the intent of this Resolution to provide subsidies for residents who are displaced by the closure or downsizing of a residency-training program. Discussion concentrated on mechanisms such as a voucher system to assure that funding for such residents would follow the residents. The subject of this Resolution was recommended for referral to the Board of Trustees for a decision allowing a more comprehensive review, and such was ordered by the House of Delegates.

Resolution 318 – Medical School Accreditation

This Resolution asked our AMA to continue its active support for voluntary LCME accreditation of U.S. medical education programs, to develop broad-based public support and policy for quality medical education, and address the recent proposed establishment of foreign medical schools operating in the U.S., who are unwilling to be chartered in the U.S. and are therefore not eligible for LCME accreditation. There was significant testimony and support for the intent of this Resolution, particularly addressing the need to protect prospective medical students and the public. For this reason, the House of Delegates elected to refer this Resolution to the Board of Trustees for a decision.

Resolution 309 – Adjusting Medical School Curricula

It was recommended by the Reference Committee that this Resolution not be adopted and such was the action of the House of Delegates. This Resolution was introduced by the New York delegation, asking the AMA to propose to medical schools that they adjust their curricula to add medical socio-economic

nomics and practice management. It was noted that the LCME standards already require medical schools to include socioeconomic subjects in the curriculum. It was further noted that practice management was a subject more relevant to residency training than to medical student education.

Resolution 313 – Transition of Responsibilities away from the Educational Commission for Foreign Medical Graduates

It was recommended by the Reference Committee that this Resolution not be adopted and this action was passed by the House of Delegates. This Resolution was introduced by the Michigan delegation, asking our AMA to 1) evaluate the Educational Commission for Foreign Medical Graduates function accountability, due process and standards of examination and its role to the United States licensing examination; and 2) to examine the possibility of the Federation of State Medical Boards and the National Board of Medical Examiners to administer the U.S. MLE to international medical graduates, as they do for United States medical graduates.

There was compelling testimony from the ECFMG regarding the mission and function of that organization. The complexity of the credentialing process, the distinction between the ECFMG certification process and medical licensure, as well as the process for determining eligibility for certification, would not make the ECFMG certification process compatible with administration by the FSMB and the NBME.

Resolution 323 – ING Representation in the ECFMG

It was recommended by the Reference Committee and affirmed by the House of Delegates action that this Resolution not be adopted, recommending that our AMA ap-

point an international medical graduate to serve as our non-staff representative to the Educational Commission for Foreign Medical Graduates.

Resolution 306 – Necessity of Clinical Skills Examination

It was recommended by the reference Committee that this Resolution not be adopted and this was the decision of the House of Delegates, as well. This Resolution was introduced by the medical students section, suggesting that the AMA and the state medical societies voice their opposition to the suggestion that graduates of Liaison Committee on Medical Education (LCME) accredited schools be required to take the clinical skills examination currently required of graduates from non-accredited LCME medical schools.

Resolution 311 – Data Bank for Poor Outcomes Associated with Excessive Work Hours

It was recommended by the Reference Committee and upheld by the House of Delegates action that this Resolution not be adopted. This Resolution was introduced by the resident and fellow section, asking the AMA to initiate an anonymous reporting network for adverse outcomes associated with working conditions and excessive work hours. The Reference Committee heard consistent testimony that the problems created by residents working excessive hours are real, significant and pervasive. The testimony was equally compelling that the operation of an anonymous reporting network by our AMA for adverse outcomes associated with excessive work hours is not the answer.

It was noted that recent changes in the operating procedures of the Accreditation Council for Graduate Medical Education (ACGME) provide for confidential reporting of violations of the institutional and/or

program requirements. A provision for reporting rapid response to egregious departure from standards has been instituted and is working well. Consensus of the testimony was that the AMA should monitor ACGME activity, rather than initiate a parallel system.

My participation as chairman of Reference Committee C was indeed quite an honor and a significant educational process for your delegate. I thank you very much for the opportunity to participate in these proceedings.

**REFERENCE COMMITTEE D
PUBLIC HEALTH**

Submitted by Rafael A. Zaragoza, M.D., F.A.C.S.

The following Reports and Resolutions were adopted:

Resolution 421 - Smoke-Free Theme Parks

Resolution 433 - Cigar Smoking

Resolution 428 - Urgent Action on States' Allocation of Tobacco Settlement Monies for Smoking Prevention, Cessation and Health Services

Resolution 415 - Immunization Registries

Recommendations in Council on Scientific Affairs Report 18 - Chemoprophylaxis for Health Care Workers and Medical Students (in lieu of Resolution 413 (1-97) and Resolution 407 (1-98))

The following Reports and Resolutions were adopted as amended or substituted:

Recommendations in Council on Scientific Affairs Report 3 - Boxing Injuries (in lieu of Resolution 404 (A-97) and Resolution 423 (A-97))

Recommendations in Council on Scientific Affairs Report 4 - Organized Medicine's Role in the National Response to Terrorism (in lieu of Resolution 426 - Bioterrorism)

and Resolution 432 - Nuclear, Biological, and Chemical Terrorism) Recommendations in Council on Scientific Affairs Report 19 - In-line Skating (in lieu of Resolution 404 (I 97))

Resolution 409 - Support for Public Health

Resolution 416 - Supporting Safe Medical Products as a Priority Public Health Initiative

Resolution 408 - Restrictions on New Adolescent Drivers - Development of Model State Legislation on Graduated Driving Laws

Recommendations in Council on Scientific Affairs Report 6 - Obesity as a Major Public Health Problem

Resolution 414 - De-alerting Nuclear Weapons

Resolution 410 - Prevention of Pneumococcal Disease

Resolution 404 - Sharps Disposal

Resolution 408 - Emergency Contraception Pills

Recommendations in Council on Scientific Affairs Report 12 - Reduction of Medical and Public Health Consequences of Drug Abuse: Update

Resolution 412 - Expanding Treatment of Heroin Addiction

Resolution 417 - Safety at Railroad Crossings

Resolution 422 - Automatic Garage Door Safety and Education

Resolution 429 - Building Environmental Health Capacity in State Health

The following Reports and Resolutions were referred to the Board of Trustees:

Resolution 407 - Healthy People 2010

Resolution 430 - Providing Safety-Type Needles for Use in Health

Care Settings

Recommendations in Council on Scientific Affairs Report 14 - Prevention and Treatment of Alcohol Use Disorders

The following Resolutions were not adopted:

Resolution 431 - Treatment of Emergency Medical Situations on Airplanes

Resolution 411 - Advocacy for the Diagnosis, Treatment and Coverage of Costs for the Care of the Overweight/Obese Patient

Resolution 402 - Expansion of Vaccines for Children Program to Cover Immunizations for Uninsured and Underinsured Adults

Resolution 425 - Vaccination Registry

Resolution 406 - Speed Bumps as a Public Health Hazard

Resolution 420 - Ban of Bovine Offal

Resolution 418 - Dioxin and Medical Waste Incineration

REFERENCE COMMITTEE SCIENCE & TECHNOLOGY

Submitted by Joseph Olekszyk, D.O.

The following reports and/or resolutions were recommended for adoption.

RECOMMENDED FOR ADOPTION

Review of Guidelines for Pre-test and Post-test Education and Genetic Counseling by the National Society of Genetic Counselors and Other Organizations

Reviews the Guidelines for Pre-test and Post-test Education and Genetic Counseling of the NSGC as well as those of other organizations. This was adopted with one caveat that Post-test protocols may differ depending on the nature of the disease and the availability of therapeutic and/or curative options.

Issues of patient confidentiality were also extensively discussed in the NSGC Guidelines.

Cloning and Embryo Research

Summarizes the scientific basis of cloning and describes the potential risks and benefits of this technology for clinical medicine and biomedical research. There was emphasis on the risks and benefits of research and the focus on public education.

Effects of Work on Pregnancy

A recommendation that a pregnant woman not perform a particular activity should not be made without consideration of the potential health consequences of working versus the hazards of not working. Physicians should encourage employers to accommodate women's physical requirements during pregnancy.

Seclusion and Restraint of Children and Adolescents

Reviews the definitions and indications for the use of restraint and seclusion. The elements of various guidelines on the use of seclusion and restraint were outlined.

Implications of Brain Development Research

Recent findings on brain development involving synaptic connections, neural plasticity and critical periods offer great promise in explaining the neuropathological and neurophysiological mechanisms underlying adverse outcomes with eventual understanding at the cellular and neurochemical levels. The CSA will continue to follow this important field of study and make additional recommendations as data become available.

Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals

Asks that our AMA support the inspection of all foreign manufactur-

ers of pharmaceutical chemicals and products which are exported to the United States to assure compliance with US standards. Periodic surveillance inspections of all foreign pharmaceutical manufacturers was recommended as well. Some concern was expressed about the availability of resources to fully carry out the recommendations.

Medical Genetics

Asks that our AMA join with the ACMG and other professional and lay organizations to publicize the resources and services offered by medical genetics professionals to other medical specialties, advocate for federal funding. Also explore appropriate mechanisms for federal support such as reauthorization of The Genetic Disease Act, introduction of a new title in the Social Security Act, and other alternatives.

E-Biomed

A National Institutes of Health Proposal to Publish Biomedical Research Reports on a Single Web Site: Asks our AMA study the implications of the E-biomed proposal from the director of the NIH for scientific publication in general and for the AMA's journals as well as possible implications for medical practice. There was some concern that this may potentially affect the journal's subscription base.

The following reports and/or resolutions were recommended for adoption as amended or substituted:

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

Prescription of Schedule II Medications by Fax and Electronic Data Transmission

Asks the AMA to encourage the Drug Enforcement Administration to rewrite Section 1306 of Title 21 of the Code of Federal Regulations to ac-

commodate encrypted electronic prescriptions for Schedule II controlled substances as long as sufficient security measures are in place to ensure confidentiality and the integrity of the information. Resolution 508 asks that the AMA lobby Congress and DEA agencies to permit the prescription of Schedule II medications by facsimile and electronic data transmission. Prescriptions for a Schedule II controlled substance may be transmitted to a pharmacy via fax provided the original written signed prescription is presented to the pharmacist for review prior to the actual dispensing. Ensuring record authenticity of the prescription to prevent diversion and maintaining patient privacy and confidentiality remain priorities for fax and electronic transmission.

Board of Trustees Report 38 – Direct-To-Consumer Advertising of Prescription Drugs

Resolution 521 – Mass Advertising of Prescription Drugs by Pharmaceutical Industry

Resolution 534 – Advertising of Medications in the Lay Media

Asks that the AMA consider acceptable those product-specific DTC advertisements that follow the guidelines for such advertisements that were developed by the AMA in consultation with the FDA, in 1993. Recommendations contained in the Board of Trustees Report 38 adopted as amended in lieu of Resolution 521 and Resolution 534. Alternatively it was noted that some ads were indeed educational and are believed to have benefited the health of the public.

Use of Blood Therapeutically Drawn from Hemochromatosis Patients

Asks that our AMA recommend against the unlabeled use for direct transfusion of blood drawn therapeutically from persons with hereditary hemochromatosis (HH)

until a means to ensure their altruistic intent is available, such as when therapeutic phlebotomies are available at no charge to persons requiring them. In particular, the concept of altruistic intent is considered fundamental to ensuring the safety of the United States blood supply and should not be compromised.

Over-The Counter Inhalers in Asthma

Asks that our AMA support strengthening the product labeling for OTC epinephrine inhalers to better educate users about patterns of inappropriate use to include that the use of OTC inhalers can be dangerous, and that the AMA encourage the FDA to reexamine whether OTC epinephrine inhalers should be removed from the market. Recommends CSA Report 2 be adopted as amended in lieu of Resolution 521. FDA review in 1994 concluded these inhalers should not be removed but that labeling should be strengthened.

Review of AMA Recommendations on Folic Acid Supplementation

Asks that our AMA encourage the FDA to require food, food supplement and vitamin labeling to specify milligram content as well as RDA levels for critical nutrients which vary by age, gender and hormonal status (including anticipated pregnancy).

Use of Opioids in Chronic Noncancer Pain: Resolution 531 – Education in Pain Medicine

Asks that our AMA encourage the appropriate education in pain evaluation and management be provided as an integral part of the core curriculum at all medical schools. Reviews issues surrounding the use of opioid analgesics in the treatment of patients with chronic noncancer pain and recommends approaches to improve the legal practice environment for physicians who appropriately prescribe these

substances. Recommendations contained in CSA Report 11 adopted as amended in lieu of Resolution 531.

Mammographic Screening for Asymptomatic Women

Based on recent summary data our AMA recommends annual screening mammograms and continuation of clinical breast examinations in asymptomatic women 40 years of age and older. Also our AMA reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

Minimal Standards for Medical Product Reuse

Asks that our AMA endorse the development of guidelines on the processing of medical supplies and instruments that may be reused. These guidelines should address the issues of product performance, safety and sterility and should be distributed to the health care industry.

Adverse Reactions of Cardiac Pacemakers Exposed to Electronic Article Surveillance Systems

Asks our AMA to adopt policies supporting the study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations on the safety of electronic article surveillance systems with respect to pacemaker use. The FDA suggested that other electronic devices exist that could potentially interfere with cardiac pacemakers and that more scientific information needs to be obtained on these devices.

Xenotransplantation Clinical Trials

Asks that our AMA study the implications of Xenotransplantation and report its recommendations. It was noted that many organizations are already beginning to study this topic.

Amend Wording of Existing Policy H-5.991 on "RU-486 Availability"

Asks our AMA to amend existing policy H-5.991 (RU 486 availability) to read as "Mifepristone." Testimony noted that the term "RU 486" was historically significant and widely understood.

Drug Initiation or Modification by Pharmacists

Asks our AMA to oppose the granting of authority to pharmacists to either initiate or modify drug treatment except on a case by case basis at the specific direction of a physician.

Direct-To-Consumer Advertising

Asks our AMA to amend its current policy as set forth in Policy H-105.989, "Advertising of Prescription Drugs to the Public" to include the words "medical devices and procedures" after "prescription drugs" in the title and throughout the body of the policy document.

Decade of the Brain

Asks our AMA work with interested national medical specialty societies as well as the NIH and other relevant federal agencies to review the successes of the Decade of the Brain initiative, summarizing the great advances in brain research and medical practice that can be understood as deriving from our 1990 action to support the launching of the Decade of the Brain initiative. Also asks this review be submitted in a report to the House of Delegates at the 1999 Interim Meeting for appropriate publication and dissemination.

Proprietary and Generic Drug Pricing

Asks that our AMA review the sudden and significant rate increases in the generic drug industry with the American Pharmacy Association, the appropriate trade associations representing generic drug manufacturers and other appropriate entities and bring any inappropriate

marketing, dispensing or incentive practices to the attention of the appropriate regulatory agencies.

Laboratory Testing Panels

Asks that our AMA study the cost effectiveness of reporting all test results generated by an automated testing procedure to the physician regardless of the individual test ordered.

Support of Embryonic Stem Cell Research

Asks that our AMA provide strong public support of federal funding for research involving human embryonic stem cells.

Support for "Off-Label" Use of Medical Devices

Asks that the AMA strongly support the important need for physicians to have access to accurate and unbiased information about unlabeled uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. Asks that our AMA ensure through its advocacy efforts with government, managed care organizations and payors that physicians are free to use FDA approved drugs and devices for other than those indications approved by the agency; and ensure throughout its advocacy efforts that coverage of drugs and devices is based on current clinical standards and not just FDA approved indications.

Prescription Compliance by Pharmacists

Asks that the AMA work with appropriate professional societies, legislative and regulatory bodies to assure that pharmacists who restrict their inventory notify patients of such restrictions and other alternatives with the approval of the prescribing physician or refer the patient to other pharmacists.

The following reports and/or resolutions were recommended for reaffirmation.

RECOMMENDED FOR
REAFFIRMATION

Drug Formularies

The AMA urges health plans to provide physicians and patients with their medication formularies through multiple media including a Web Site on the World Wide Web. Asks that our AMA urge that any managed care organization or insurance company which distributes a drug formulary to health care providers or pharmacists must, in addition to paper copies of such formulary, also distribute as electronic media, preferably using a national standard format. HOD Action Section 9 of Policy H-285.965 – Managed Care Cost Containment involving Prescription Drugs reaffirmed in lieu of Resolution 511.

FDA Regulation of Nutritional Supplements

Asks that our AMA work with the FDA to educate physicians and the public about the FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support the FDA's efforts to create a data base. Resolution 515 asks our AMA House of Delegates to seek passage of federal legislation establishing the Food and Drug Administration's authority to regulate nutritional supplements. HOD Action: Policy H-150.954 – Report Adverse Effects of Drugs, Vitamins and Herbs reaffirmed in lieu of Resolution 515.

The High Cost of Both Prescribed and Over-The-Counter Medication

Asks that our AMA educate and inform the public about the high cost of medications and the fact that the

AMA is in favor of plans to address these expenses. HOD Action: Policy H-110.995 – Excessive Cost of Prescription Drugs H-110.999 – Cost of Prescription Drugs, H-110.997 – Cost of Prescription Drugs and H-110.998 – Cost of New Prescription Drugs reaffirmed in lieu of Resolution 520.

Women's Health: Gender Based Differences in Health and Disease

This report discusses recent pertinent findings on gender based differences in health and disease. The CSA agreed with testimony that the report was incomplete and asked to reconsider the report. Therefore CSA Report 13 was referred.

Use of Antimicrobials in Consumer Products

Asks our AMA to study the effectiveness of antimicrobial agents in consumer products and the possible long-term implications of their use, and then make recommendations regarding consumer education and government regulation of these products. Concern was expressed about whether the AMA should be the organization studying this matter and if so that the fiscal note on such a study would be high. Resolution 506 was referred.

Health Plan Formularies and Legislation

Asks that our AMA study the impact and advisability of federal and state legislative response to health plans limiting patient access to pharmaceuticals through formularies with a report at the Interim 1999 Meeting. The Reference Committee believed that a study as requested by Resolution 524 would require a multidisciplinary approach. Resolution 524 was referred with a report at I-99.

The following reports and/or resolutions were not recommended for adoption.

NOT RECOMMENDED FOR
ADOPTION

Increased Funding for Prostate Cancer Research and Education

Asks our AMA to use its offices to urge the federal government to increase funding for research of cancer of the prostate and also to increase funding for education of the public and physicians on different options available for treatment and management of prostate cancer. Those speaking against adoption acknowledged that the cause of increased funding for prostate cancer is worthy but recommended that the language be broader and more generic e.g. "increase funding for research on all malignancies" or that AMA efforts should be decided by factors such as disease incidence.

Prominent Notice of Product Reformulation on Cosmetic Products

Asks our AMA to seek passage of federal legislation requiring that any changes in the formulation and the date of change of a cosmetic preparation be prominently displayed on the container and the outer wrapper. The FDA suggested that the current labeling regulation adequately provides consumers with information on the composition of cosmetic products offered for sale. By reviewing the product ingredient declaration consumers can avoid using or coming into contact with products that contain ingredients to which they are sensitive, allergic or otherwise wish to avoid.

Asthma Warning Labels for Yellow Dye Number Five Food Coloring

Asks our AMA to seek legislation that would require clear ingredient labels to be placed on all edibles and drugs which contain Yellow Dye Number 5. Testimony related regulations in force since 1980 have required label notification of the presence of tartrazine in any consumer product. The FDA con-

cluded that a simple listing of the color among the list of ingredients is sufficient to alert susceptible persons to the presence of the color.

Drug Interactions

Resolution 518 asks that Policy H-165.896 (Section 7B) be clarified by further amendment by addition and deletion as follows: ...incorporate reviews, including discussions about medication side effects and known drug interactions (i.e. with other prescription drugs, with OTC drugs, with foods, and with beverage alcohol) as part of routine office-based practice. The current AMA policy H-165.896 is sufficient to guide physician behavior.

AMA Support for National Screening for Peripheral Vascular Disease

Asks that our AMA express its support for national screenings for PVD and their goal of increasing public awareness, prevention, early detection and treatment of PVD. Testimony on this resolution was extensive and generally did not support PVD screening. The opponents of this screening cited the fact that PVD is a fairly advanced symptom of other problems and that there is currently no published evidence supporting mass screening of this disease.

The Decade of Pain Control

Asks our AMA to petition the U.S. Congress to declare the next decade as "The Decade of Pain Control". Testimony against the resolution did not dispute the importance of pain control as an issue but argued that the AMA should consider all alternatives.

REFERENCE COMMITTEE F BOARD OF TRUSTEES

Submitted by Carol A. Tavani, M.D.

The following is a brief summary of the activities of Reference Committee F, Board of Trustees, of the 1999 Annual Meeting of the AMA House of Delegates.

The following Reports/Resolutions were recommended for adoption:

Board of Trustees (BOT) Report 1

Recommended that representatives from foreign nursing schools be allowed to attend the House as observers, thus forming better relations with AMA.

BOT Report 20

A revision of AMA's principles on Corporate Relationships (largely a reiteration of that presented at I-98).

BOT Report 24

Supported the existing AMA Vision Statement and Strategic Plan.

BOT Report 26

Keeps dues at the present rate and establishes a 10 percent rebate for unified states' members for 2000.

Council on Long Range Planning and Development (CLRPD) Report 1

Sets forth guidelines and an administrative process for admission of professional interest medical associations.

CLRPD Report 2

Includes effort to clarify apparently conflicting portions of the AMA Strategic Planning Process. A notable recommendation was a shift of timeline to 12, not 18 months.

CLRPD Report 4

A consolidation of policies on drafting reports and resolutions.

Resolution 612

Recommends the annual financial disclosure of grants and donations to the AMA.

The following were adopted by amendment or substitution:

Resolution 602

Advocates maximization of Web-based strategies, earlier posting of House business on the AMA Web Site, and chat areas.

Resolution 603

Advocates that AMA disseminate options by which members may have their names excluded from distribution.

Resolution 616

Increasing ethnic medical society representation, but cautions against becoming too divided/split.

Recommendations of the Task Force on Membership and Resolution 613

Establish that an ongoing body will continue to address this issue (membership has declined from 65 to 32 percent in recent years) after the Task Force sunsets. (Recommendation 7, which asked that only AMA members elect specialty society members, was not adopted).

Resolution 605

Distribution of the AMA Code of Medical Ethics be distributed to all medical students.

Resolution 606

Addressed reduction of the tuition cost for the Leadership meeting; the substitute endorsed reduction, but not necessarily by 50 percent; a report back at I-99 was requested.

Substitute Resolution 609

Establishes a formal training program for Delegates and Alternates, with recognition of the special needs of smaller states.

Resolutions 610 and 619

These resolutions involve AMPAC contributions and allocation of funds. It was agreed that tobacco money control be utilized as leverage in supporting politicians, and that the legal right to bargain collectively be advocated by this mechanism.

Substitute Resolution 611

Encourages participation in the bi-annual Grassroots Conference in D.C., and participation in other meetings held in the Capitol on alternate years.

The following were referred to the Board of Trustees:

Resolution 604

Asked for earlier submission deadlines for resolutions as well as Web-based strategies for dissemination.

Resolution 607

This resolution deals with Policies and Actions, and advocates a tri-level prioritization strategy for each proposal.

Resolution 608

Encourages development of policies and processes for appropriate and efficacious disbursement of medical supply donations to foreign countries.

Resolution 618

Calls for streamlined, efficient methods of membership application and collection of dues.

Resolution 620

Raises the issue of how best to support and advocate for victims of the war in Kosovo.

Resolution 601

Addresses effectiveness of the House of Delegates meetings, was referred, with a report back at I-99.

The following were filed:

Recommendations of the Interim Report of the Committee on Trustees' Compensation.

Status Report of the Commission on Unity.

Auditor's Report (BOT 2).

BOT Report 34, an update on the Federation Coordination Team.

Recommended for reaffirmation, but extracted from the consent calendar, was the Report of the Special Advisory Committee to the Speaker. The House voted to change the Interim meeting to November, but to delay implementation until 2005.

Resolution 617, which cited the Executive Vice President for Distinguished Service, was withdrawn.

**REFERENCE COMMITTEE G
MEDICAL PRACTICE/FACILITIES**

Submitted by Kelly S. Eschbach, M.D.

Medicare Managed Care – Opt Out Rules

This resolution calls for the AMA to oppose managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan but patients who can't must choose new doctors. It also calls for the AMA to support current proposals to extend the 30-day waiting period limiting when Medicare recipients may get out of managed care plans; and to support changes in HCFA regulations that would require Medicare managed care plans to notify patients immediately whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and give affected patients a

reasonable opportunity to switch plans.

Coercive Contracting

This resolution asks the AMA to study the prevalence of hospitals requiring hospital-based physicians to accept all managed care contracts negotiated by the hospital without physician input.

Council on Medical Service – Report 11 – Medicare Review Activities; Peer Review Organization Sixth Scope of Work, Medicare Integrity Program and Carrier Post-payment Audit Processes.

This Report provides an update on Medicare review activities; urges HCFA to provide physicians with the opportunity for significant comment and input in the development of MIP and the PRO program; and to delete any "bounty" system or other "incentives" and "award fees" from the PRO Sixth Scope of Work and MIP.

Board of Trustees Report 16 – Appropriate Medical Coverage for Medicare Beneficiaries

The report calls for continued study of the impact of plan withdrawals on Medicare patients; and recommends monitoring and advocating for legislation and regulations that would protect beneficiaries whose plans withdraw, while stressing that regulations should support free-market choice of plans. It also calls for continued promotion of adequate network standards to HCFA.

Point-of Service Referrals of Surgical Pathology and Cytopathology Specimens

The resolution calls for amending AMA Policy H-165.908, so that the optional and affordable "point-of-service" type feature includes allowing patients to self-refer to physicians, hospitals or surgical pathology and cytopathology services outside of the plan at additional cost to themselves.

Denial of Hospital Staff Privileges

This issue generated much debate on the floor and was ultimately referred back to the Board of Trustees for further study and a report. This resolution attempted to deal with the issue of denial or loss of hospital staff privileges for physicians who do not admit or attend a designated minimum number of patients or do not perform a certain number of procedures. Discussion also focused on the fact that because staff privileges are denied or lost, physicians may then be denied participation in some managed care programs.

Confidentiality Agreements in Managed Care Organizations – Contracts with Providers

This resolution asks the AMA to reaffirm Policy H-285.961, which states that "Managed care organizations have the right to protect proprietary information, as long as such protection does not prohibit physicians from disclosing relevant information to patients."

Council on Medical Service Report 4 – Coerced Employment of Physicians

This resolution recommends that physicians who believe they are being coerced into specific employment arrangements contact the AMA/State Medical Society Litigation Center, their state medical association and/or legal council.

Clinical Research in Managed Care

This resolution asks the AMA to study the degree to which managed care organizations support and participate in clinical research.

Compensation for Emergency On-Call Services

This issue generated lengthy and mixed testimony regarding availability of emergency on-call service. It was noted that a report is currently being developed by the Council on Medical Service, in consultation with both the American Hospital Association and the American College of Emergency Physi-

cians, and that the resolution would be referred to the Board for decision, pending the report.

Education about HMOs as Payers for Health Care

This resolution reaffirms AMA Policy H-285.998, which states that "all health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees, in a standard disclosure format, those services which they will and will not cover, and the proportions of plan income devoted to utilization management, marketing and other administrative costs."

Medicare Pre-Pay Audits

This resolution asks the AMA to work with the Practicing Physicians Advisory Council to influence those Medicare review measures that have the potential of significant disruption and cost to physicians practices.

Eliminating Pre-Certification

This resolution 1) reaffirms AMA Policy 130.970, which advocates against any health plan requiring prior authorization for emergency services; 2) asks the AMA to advocate that all utilization review efforts focus on statistical outliers; 3) asks the AMA to advocate that managed care plans restrict their entire pre-authorization requests to physicians whose claims have been shown to be statistical outliers; and 4) asks the AMA to encourage HCFA to adopt legislation not allowing secondary payers to use independent pre-certification requirements.

Binding Primary and Secondary Payers

This resolution asks the AMA to seek legislation to ensure that the pre-certification of the primary insurer be binding on all secondary payers, and that if there is no pre-certification required by the primary insurer, that the secondary insurer must honor their financial obligation.

Physician Control of Diagnostic Imaging Studies

This resolution asks the AMA to seek relief from inappropriate pre-authorization requirements for emergency and urgent diagnostic imaging procedures.

Denial of Care and Appeal Mechanisms by Managed Care Companies

This resolution asks the AMA to study the true existence and extent of managed care denials of care, and appeals to independent review entities.

Further Defining "Medical Necessity to Include Functional Disability"

This resolution asked that the AMA's definition of medical necessity include all health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations. It is the rehabilitation and functional impairment piece of the definition, that was not previously included. Though many agreed that these were important issues, it was felt that the current definition should continue to be used for now, as it has been effective in recent legislative campaigns that benefit patients. The matter was referred to the Board of Trustees for final decision.

REFERENCE COMMITTEE H HEALTHCARE DATA/SYSTEMS

Submitted by Stephen Permut, M.D.

This committee dealt with a variety of practice related issues, including the distinctions between supervision and proctoring of facility medical staff and the use of surgical assistants other than licensed physicians. Neither of these policies reflect a change in practice from that which is currently standard in Delaware.

The evaluation and management codes were, again, addressed, and the policies adopted in June and December, of last year, were reaffirmed. This includes working with HCFA to greatly simplify the codes and to reduce the aspects of counting of elements of the history and physical examination to the greatest degree possible. There was also established an AMA Task Force, the role of which will be to identify problems with the proposed E&M coding system and to propose solutions to those problems.

The Committee also adopted a Board of Trustees' Report dealing with the Utilization Management guidelines and set forth a series of criteria to be sure that such guidelines lead to appropriate patient care. These criteria include that the guidelines be based upon sound clinical evidence, that they are developed by practicing physicians, that there should be opportunity to deviate from the guidelines based on specific patient needs, that there should be clear-cut appeals mechanisms when patients and physicians feel it is appropriate to deviate from guidelines, and finally, that the guidelines should place the best interest of the patient above all other criteria.

There was also a resolution encouraging hospital medical staffs to retain counsel that is independent of the hospital's attorneys.

The committee approved a resolution to require health plans that adopt the resource-based relative value scale (RBRVS), to adopt it and use it in the same fashion as the federal government and use it according to the definitions in the CPT manual.

There was another resolution passed for the AMA to oppose the development of a federal government fraud data bank, because of the difficulties that the government has had in differentiating between true fraud and billing errors.

There was another resolution passed discouraging the government and other third-party payers from utilizing the patient medical record as a means of auditing the financial aspects of patient care, and to reiterate that the physician's office medical record is the property of the physician but that the information should be readily available to the patient.

Another resolution was adopted to encourage HCFA, while developing the evaluation and management code guidelines, to include patient encounter time as an additional measure of physician effort when coding these services.

Another resolution developed the principles for prescribing over the Internet with the most significant principle being that a physician should only so prescribe when an actual physician/patient relationship exists.

Another resolution was passed to encourage the federal government and other third-party payers to develop the use of "smart cards" for their patients' insurance cards to make office practice more efficient and to allow ease of determination of eligibility and limitation of benefits.

The remainder of the activities of this Committee were either referred to the Board of Trustees for further investigation or not adopted.

REFERENCE COMMITTEE I

Submitted by Stephen Permut, M.D.

This was the most controversial of the reference committees that met this year, and it dealt with the concept of collective bargaining for physicians. Three groups of physicians were addressed separately, in the nine resolutions that were adopted. These include: interns, residents and fellows; employed physicians; and self-employed physicians. A series of overriding

principles were also adopted, and these include the maintenance of the highest levels of professionalism and agreements that will be consistent with the principles of medical ethics and the current opinions of the Council on Ethical and Judicial Affairs of the AMA.

With regard to employed physicians, the AMA resolved to immediately implement a national labor organization to support the development and operation of local negotiating units as an option for employed physicians. For interns, residents, and fellows, similarly the AMA resolved to implement a national labor organization to support the development and operation of local negotiating units. In both cases, this would be an option with less formalistic options also available.

In the case of employed physicians informal options would include the existing private sector advocacy programs that are available, and in the case of interns, residents, and fellows, it would be the availability of the AMA to resolve specific conflicts as they come up and to assist in the formation of independent house-staff organizations to assist interns, residents, and fellows in their negotiations with their hospital employers.

With regard to self-employed physicians, the AMA will continue to strongly advocate for the passage of antitrust reform legislation that would allow physicians to come together to collectively bargain with managed-care organizations. In this case, the availability of the AMA's private sector advocacy programs would also be available.

In all cases, the formation of such organizations, be they, collective bargaining units, private sector advocacy programs, or independent house-staff organizations, striking or withholding patient care would be precluded. Thus, the purpose of these organizations

would not be to negotiate the financial terms of the various agreements, but rather to negotiate contract terms that would serve to improve patient care.

THE AMERICAN MEDICAL ASSOCIATION YOUNG PHYSICIAN SECTION

Submitted by Kelly S. Eschbach, M.D.

The American Medical Association's Young Physician Section (AMA-YPS) held its Annual Assembly Meeting on June 17-18, 1999, in Chicago. The AMA-YPS Assembly is composed of delegates representing their constituent state medical societies, specialty societies and various branches of the uniformed services. Representatives are AMA members and are under the age of 40, or have been in practice less than five years if they are over the age of 40.

The following is a brief summary of resolutions presented for debate and votes by the AMA-YPS Assembly:

Expansion of HEAL Loan Consolidation Program

1) Offers AMA-YPS support for the AMA's efforts to implement a low interest loan program that provides low cost original and consolidated loans for medical education. 2) Asks the AMA-YPS to encourage the AMA to take action toward amending federal regulations, and simplifying the loan consolidation/refinancing process, and to allow refinancing of HEAL loans.

Truth in Herbal, Vitamin, and Dietary Supplement Advertising

Asks the AMA-YPS to: 1) re-affirm current policy for the AMA to work with the FDA to educate physicians and the public about the FDA's Med Watch program, to encourage physicians and the public to report adverse events associated with dietary supplements and herbal remedies, and to create a data-

base of such adverse events; 2) work with Congress to modify the Dietary Supplement Health and Education Act to require dietary supplements and herbal remedies to undergo FDA approval for evidence of safety and efficacy; 3) encourage the AMA to work with Congress and the Federal Trade Commissions to require such products' advertising campaigns to identify non-physician spokespersons as "actors;" 4) ask the AMA to study and report back on the possibility of seeking labeling requirements similar to those required for alcohol and nicotine containing products.

Antitrust Aspects of Board Certification

Asks the Governing Council to study and report on the potential antitrust aspects of board certifications.

Practice Management Education in Residency Education Program

Asks the AMA to: 1) survey senior residents and recent graduates to determine their exposure to practice management issues during their residency programs; 2) survey residency program directors about inclusion of practice management issues in their curriculum; 3) work with other national medical specialty societies to develop guidelines for such a curriculum.

Mandatory Use of Hospitalists

Opposes mandatory use of hospitalists for inpatient care and asks the AMA House of Delegates to do the same.

Drug Abuse in the Communities

Asks the AMA to oppose the distribution, manufacturing and sale of "designer drugs" in the U.S.

Report H—Providing Value to Young Physician Members and the Profession

Generally supports the AMA's Membership Task Force report, which is concerned with declining AMA

membership, particularly among young physicians.

Report B—Facilitating Entering Into Practice

Asks the AMA-YPS and the AMA to assist young physicians' transition into practice by advocating a more streamlined credentialing process for licensure and board certification.

Report J- Specialty Society Representation in the AMA-YPS Assembly

Presents the criteria for specialty society representation, gives an update on the level of specialty society representation in the Assembly, and provides information about the upcoming five-year review process facing those specialty societies seated in 1994.

Report M—Roles and Responsibilities of AMA-YPS Assembly Representatives

Specifies roles and responsibilities of representatives in the areas of communication, membership, leadership, and advocacy, which will allow the AMA-YPS to become more visible, effective, and active and thus make young physicians stronger advocates for themselves and their patients.

Report O - Sunset of Designated Young Physician Position on the AMA Board of Trustees

Asks the AMA-YPS to submit a resolution to the AMA House of Delegates Interim 1999 Meeting requesting a change in the AMA By-laws which would retain a designated seat for a young physician member on the Board of Trustees.

Report A—Collective Bargaining: An Essential Component of Private Sector Advocacy

Recommended that the AMA 1) develop and implement a national labor organization for employed physicians and residents; 2) support legislation for anti-trust relief for self-employed physicians;

3) educate physicians regarding the issues of collective bargaining and the availability of the AMA's Private Sector Advocacy group. (See Reference Committee I report from the AMA-House of Delegates.)

Report F- Medical Staff Development Plan

Asks the AMA to study the impact of hospital medical staff development plans and determine whether some may be illegal restraints of trade under current antitrust laws.

Report C – Fee Schedules

Asks the AMA-YPS to disseminate AMA model legislation to require health carriers to allow access to their payment policies, rules, and fee schedules.

Report D- Reimbursement for Low Vision Aids

Instructs the YPS Governing Council to study and issue a report regarding potential Medicare funding for low vision aids.

If you wish to learn more about The Medical Society of Delaware's Young Physician Section, or the AMA-YPS, and how you may participate, please contact the MSD office at (302) 658-7596, or Kelly S. Eschbach, M.D. Chair, MSD-YPS at (302) 428-6600.

ORGANIZATION OF STATE MEDICAL ASSOCIATION PRESIDENTS

Carol A. Tavani, M.D.,
OSMAP Steering Committee

The following are highlights of the semiannual meeting of the Organization of State Medical Association Presidents, held in conjunction with the Annual Meeting of the AMA on June 18, 1999.

Confidentiality and Utilization of Human Genetic Information

This topic had initially been raised at the last meeting. Concern was

expressed over the possible formation of a data bank or repository of genetic information, the confidentiality of which might well be compromised. Of particular concern is the importance of preventing utilization of this information by insurance companies. Apparently some companies already offer free genetic testing. Legislative efforts regarding utilization of these results have already been initiated, and AMA has policy on this, stating essentially that it should not be released, but the sentiment was that the AMA take a proactive stance therein.

Health Care Surrogacy

Another topic revisited from last time, this concerns the existence of organizations emerging as a "cottage industry" which market the service of acting as one's guardian, advocate or surrogate. Community resources such as AARP, which has volunteer counselors for elderly patients, and state ombudsman programs for patient advocacy, do exist. The suggestion was made that AMA should study this, and that CMS may be the appropriate venue.

Collective Bargaining

This will be the subject of discussion in Reference Committee I. AMA surveys overwhelmingly support efforts to achieve legal permission to negotiate. The present situation is that only employed physicians and resident physicians in nonsupervisory roles have the legal right to do so. However, two thirds of all physicians are not thus protected. Relief from current antitrust laws is needed, and the Council on Legislation has been working on this matter. The position of the Board of Trustees is against collective bargaining, and the essence of the basis for this posture appears to be the wish to avoid running afoul of the law. Texas has legislation awaiting gubernatorial signature (actually at the time of compilation of this report, Governor

Bush had in fact just signed the bill into law) which allows physicians to bargain collectively so long as the State directly supervises. Dr. Berry summarized features of the bill, which include that physicians may not withhold care (i.e., strike). New York has similar legislation pending. Illinois is pursuing similar efforts, as is Massachusetts. Colorado has meetings with the state HMO Association, with recommendations made having a very high rate of adoption. Medical societies of other states, such as Ohio and Florida are also engaging in such non-binding discussions of patient care issues.

Conflict Resolution (i.e., between and among elements of the Federation)

It was acknowledged that it is the responsibility of the component parts to achieve effective means by which to do this, and that the need to do so is critical.

Kosovo

The Wisconsin Delegation's President-elect raised concerns regarding Kosovo, seeking assurance that AMA and its membership is concerned about the atrocities there, some targeted toward physicians as well as the populace. It was pointed out that Dr. Daniel "Stormy" Johnson has been President of the World Medical Association, and would appear an ideal channel for this issue.

EMTALA (The Emergency Medicine Treatment and Labor Act)

EMTALA, the subject of Nebraska's Resolution 209, was discussed. The point was made that when this law was passed, there were ramifications not initially evident which potentially impact negatively on the practice of medicine. Delegates from Louisiana and Oklahoma elaborated on this.

Use of Hospitalists

Heard discussion by numerous states, including Florida (wherein this is a priority item on next year's legislative agenda) and Missouri. The consensus was that the use of hospitalists should be voluntary, and determined on an individual basis. Dr. Monahan of Virginia pointed out that this is also a patient's rights issue, has been considered for the past two years at the Organized Medical Staff Section (OMSS), and that the hospital bylaws are an appropriate venue wherein to address such policy.

AMAP

A summary of survey results from 45 responding states was presented by Dr. Ellis (Louisiana). Many states have developed or are developing their own profiling mechanisms. Concerns expressed included competition with these local/regional efforts, as well as use of this body of information (e.g., for economic credentialing) by third party payers.

States' Use of Tobacco Money Settlement

Heard much discussion from numerous states (the tobacco industry promised over 200 billion dollars to states over the next 25 years). The need to work with other concerned associations, such as the Cancer Society, in order to establish a broad-based consensus to effect and ensure that those monies be directed toward health, was stressed. In New Hampshire, all the money has been earmarked for education, not health. In Michigan, the governor decreed that 85 per-

cent go to schools, for deserving students. In Alabama, the money was directed toward various industries, but the physicians and AHA were able to achieve redirection such that \$40 million goes into Medicaid. In Oklahoma the governor vetoed the money going into health care and redirected it into the general fund. On a more positive note. In Minnesota, the intent is to use the money for tobacco-related health matters, and Nevada's state government is pro direction toward health matters. Missouri was the first state to file suit and achieve a settlement/trust fund wherein tobacco money and earnings from it can be used only for health care. In Florida, the money was directed to the general fund despite efforts of the health care community, which has now sought a Constitutional Amendment.

Shared Services Organization

A proposal has been developed by New York, Ohio, Texas, California, the American Association of Otorhinolaryngologists, and the AMA to form a Shared Services Organization, which would increase the value of membership through group purchasing and other means. Considerable business expertise and perspective were brought to this project.

Promotion and Sales of Complementary Medicine Products by Physicians' Offices and Related Enterprises

Caveats were expressed concerning jeopardizing the professionalism of medicine. There is existing CEJA opinion on this topic.

E/M Guidelines

California's president noted that the new guidelines, which are still not consistent with what our House of Delegates had recommended last year, are out. HCFA has promised California a pilot project, which would run HCFA's criteria concomitantly with those of California, and thus demonstrate which are superior. A late resolution in OMSS (Missouri) as well as HOD Resolution 820 (Oklahoma) address KIM concerns, the essence being that the medical record is a tool with which to deliver health care, was not intended for other purposes, and that efforts to do so are disruptive to the physician-patient relationship.

Medicaid Waiver

Tennessee's unfortunate experience with the Medicaid waiver was described.

The "Criminalization of Medicine"

Referring to instances wherein a physician has been found not to have acted unprofessionally by the state's Board of Medical Practice, but has been found guilty by the legal system, was discussed.

vfed.org

The website of the Federation. OSMAP is planning to institute a discussion forum on that website, to enhance and expedite communication and share information, such as the above highlights, in the most efficient manner possible.

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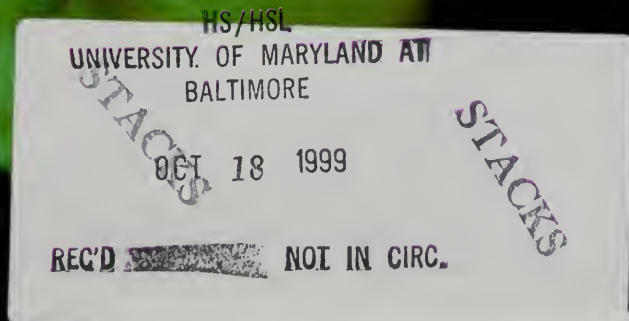
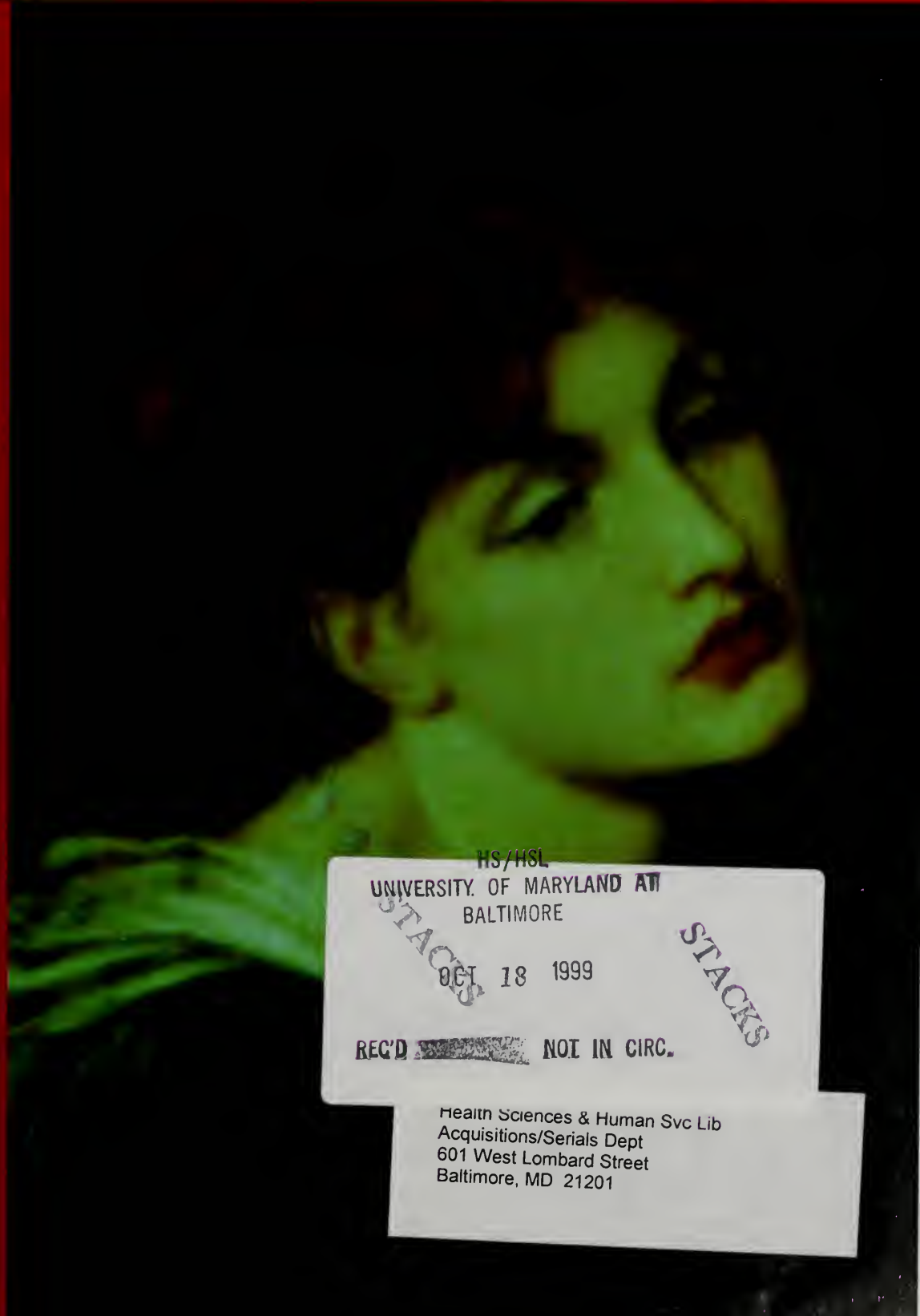
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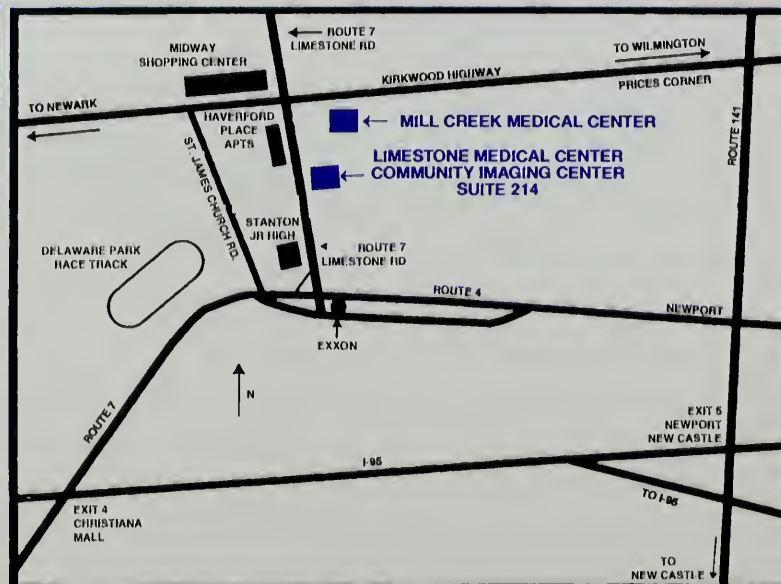
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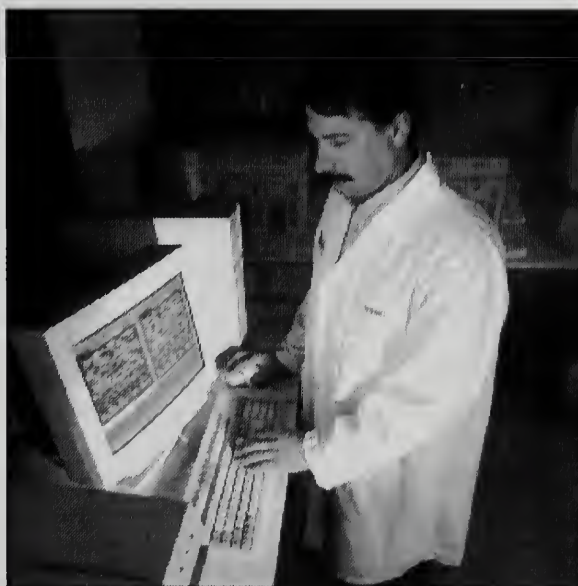
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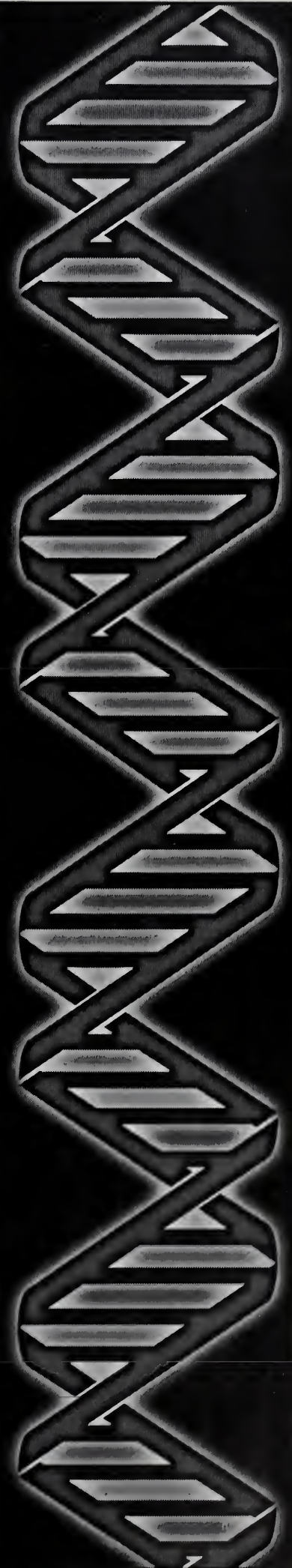
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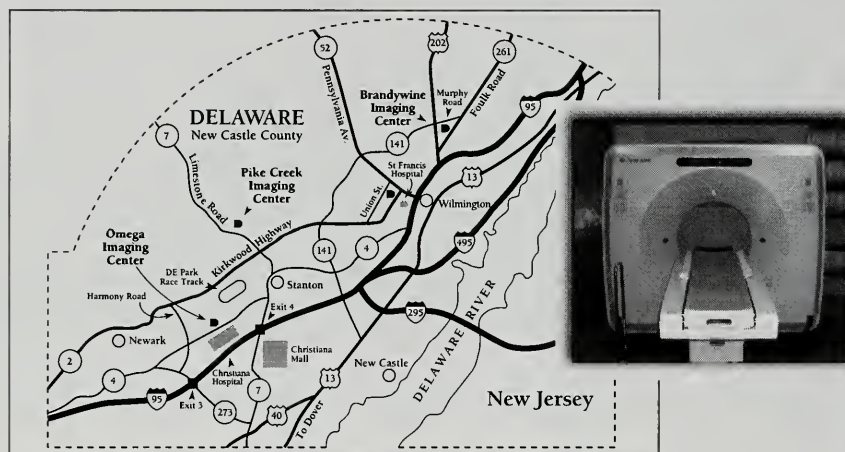
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On the Cover: Veronica Veronese (Detail) ... Painted by Dante Gabriel Rossetti in 1872. It can be seen at the Delaware Art Museum in a dramatic Victorian setting. It is part of what is recognized internationally as the most important collection of Pre-Raphaelite art outside of England. For more information, please see page 398.

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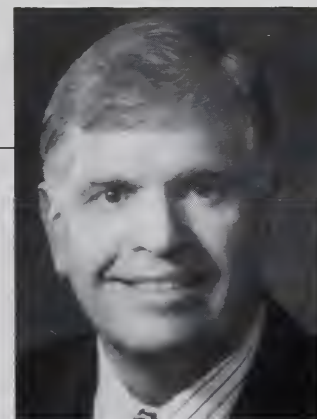
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Breast Cancer Management, Its Triumphs and Challenges

Martin G. Begley, M.D.



In writing his *De Medicina* in 23 A.D., Aulus Cornelius Celsus described what he considered to be the best approach for the management of breast cancer. He recommended excision of the lump but only in its early stages adding that after that there was little that could be done for the patient. Nearly two millennia would elapse before physicians had the technology that would allow them to closely follow the advice of this prescient physician of ancient Rome. The current issue of our journal is dedicated to these new diagnostic techniques and the public health initiatives that make them widely effective.

Today, the availability of high quality mammography techniques permit earlier diagnosis of breast lesions than was considered possible twenty, never mind two thousand, years ago.

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, Delaware. He is the president of the Medical Society of Delaware.

Furthermore, mammography's safety, through reduction of radiation exposure, has made this technique useful for regular screening of women permitting very early detection of breast cancer. As a radiologist, it is heartening to note that through these efforts, in my practice, it is now rare to see breast lesions that are more than one-centimeter in size.

Mammography has a drawback: it is very sensitive but not specific. A high percentage of areas that are suspicious for malignancy on mammography are not, yet women have to undergo biopsies of them to prove they are benign. Until recently, the only way to do a breast biopsy was to use the traditional open surgical procedure. Fortunately, new stereotactic techniques allowing relatively non-traumatic biopsy of breast lesions have been developed. These require an incision that is less than a centimeter, often make open biopsies unneces-

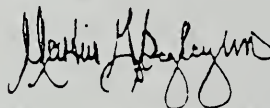
sary and are available throughout Delaware. Women undergoing stereotactic biopsy are often able to attend social events only a few hours later; some mention that they went back to work in the interval.

As a result of these diagnostic imaging advances in diagnosis and biopsy techniques, most breast lesions can be discovered and histologically evaluated at a stage in their development when cure is likely.

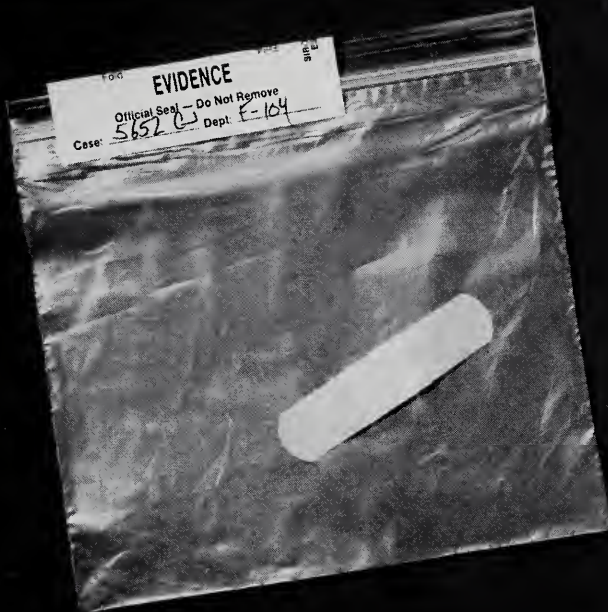
Diagnostic imaging technology has not been the only factor that is helping in the fight against breast cancer. Admirable public health work has made extensive contributions. Widespread public education by innumerable public and private groups, working in concert to gain media attention, has been essential to alerting women to the importance of getting a mammogram. Also, the individual work of prominent women who have developed breast cancer themselves — Mrs. Betty Ford especially comes to mind — have shown deep generosity during a time of great physical and emotional stress by discussing their disease openly and encouraging other women to care for themselves. They have put a human face on breast cancer statistics. And many community volunteers and professionals have organized self-breast examination instruction and "Reach to Recovery" programs. There are still challenges in dealing with this disease. Only about 56 percent of the women

who should be obtaining regular breast screening do so. Also, studies have shown that some physicians fail to encourage their patients to get these necessary exams. Other challenges also exist: What advice are we to give the women who carry a gene that is associated with an increased risk for cancer? Which women should receive drugs that may reduce the incidence of breast cancer given that no drug is without side effects and no one should be advised to incur expense for unneeded care? What preventive actions, such as diet modification, can be taken to limit the number of cancers that will develop? More questions will arise with advances in pharmacologic and gene therapy and other discoveries that result from basic and clinical breast cancer research.

We have a great deal to be grateful for in the progress made in the diagnosis and management of breast cancer and, in turn, that progress offers hope for even more progress. Additionally, the multi-disciplinary approach used to develop diagnostic, therapeutic and public health strategies for breast malignancy will serve as a model as we seek solutions for managing other diseases.



Martin G. Begley, M.D.
President



*e*xhibit A:

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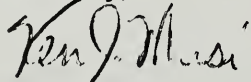
To: Medical Professional
From: Ken J. Musi
Re: Health Care Real Estate in Delaware

Within the field of medicine, physicians specialize in order to best meet the medical needs of their patients. As a commercial real estate agent, I have done likewise for equally important reasons. By becoming an expert in the field of real estate specifically suited for the Health Care industry, I have helped hundreds of physicians and medical groups acquire, sell or lease space appropriate for medical practices and health related facilities.

Since beginning my career in 1989, I have built a client base that has come to value the knowledge and expertise that I have acquired through this specialization in real estate. Many Physicians, Residential real estate agents, attorneys, accountants, and other Commercial real estate agents also recognize the importance of such a specialty, with much of my business resulting in referrals from this important professional network. Some of my clients have included: Blue Cross Blue Shield of Delaware, the duPont Hospital for Children, St Francis Hospital (Franciscan Family Care), Riverside Hospital, Christiana Care, First State Orthopaedics, The Delaware Heart Group, Gastroenterology Associates and many more. In addition, I have also assisted many physicians in finding suitable sites to develop an office building either for their business or for the purpose of investment. Whether assisting physicians just completing residency, or business managers of large practices, my real estate expertise in the Health Care field can be of tremendous value. As a member of the DMGA (Delaware Medical Group Managers Association), I remain involved in the concerns and issues facing the medical community providing an extended benefit to all of my clients.

Should you have a building suitable for Health Care use, please call me if you plan to sell or lease. Within my database may be someone needing exactly what you have. If you are looking for space to start a practice, move a practice, or add additional locations, check with me first as I will probably be aware of a building or location perfect for your needs. My goal is to provide the highest quality of service while offering you the greatest level of expertise as it relates to your real estate needs in leasing, buying or selling property in the specific area of Health Care. I look forward to hearing from you.

Sincerely,



Ken J. Musi



Mammography for Senior Women: An Overview

Edward R. Sobel, D.O.

Busy practitioners seem to delay breast cancer screening of Medicare aged women. These women often have a number of medical problems demanding immediate care. Consequently, preventive care may be neglected. Because of this, and the low level of mammogram screening of Medicare women, Quality Insights of Delaware (QID) (formerly WVMi) has strongly encouraged this issue of the *Delaware Medical Journal* which is devoted to breast disease, diagnosis and treatment. It is hoped that by making physicians aware and increasing their acumen on such an important topic, mammography rates will increase in this group of women who are at highest risk of death from breast cancer.¹

Since 1979, the rate of breast cancer mortality has significantly decreased in women ages 45-

54, but not in older women.¹ Breast cancer is the most common cause of cancer death in women more than 65 years of age.² The incidence of breast cancer increases up to age 80 and then plateaus during the next five years.³ In a statewide random sample interview done in 1997 by WVMi, 92 percent of Delaware Medicare beneficiaries were aware of the importance of mammograms, yet claims data for 1996 show rates as low as 15 percent for African-American patients in Kent County. The rate never exceeded 35 percent for any group.

What would it take to make a difference? Study-after-study has shown that physician recommendation is the most powerful predictor to getting a screening study. Those who receive encouragement from their doctor are 4 to 12 times more likely to have a mammogram. Prescribed mammo-grams have a 70 percent compliance rate, whereas self-referred mammograms have only an 18 percent

Edward R. Sobel, D.O., is the HCQIP Director for Quality Insights of Delaware.

completion rate.⁴ The most common response to the survey question, "What would most motivate women to get a screening mammogram done" is, "if my doctor told me to."

Why are mammograms not prescribed or performed?

- **"The gynecologist is taking care of it."**

As women age, they are less likely to see the gynecologist. They see the primary care physician typically three or more times per year. It is easy to add a clinical breast exam and a referral for a mammogram at one of those visits.

- **"My patient is too old or sick to benefit."**

The primary care physician can balance considerations of longevity, co-morbidity, etc. The American Geriatric Society currently recommends screening mammography for women up to 85 years of age whose life expectancy is three years or longer.⁵

- **"I wait for the patient's yearly full exam/PAP test."**

This examination occurs less frequently as patients age. Since it is likely that the woman is seen for various reasons at several times throughout the year, she can be recommended for an exam at any visit.

- **"I am not sure how often a woman should get a mammogram."**

Recommendations for appropriate screening and Medicare rules can be found on page 403 of this issue of the *Delaware Medical Journal*.

- **"I forget to remind the patient."**

The QID has distributed a tool kit to all primary

care doctors in the state. In this tool kit are a number of items, including a list of all facilities in the state which offer mammograms, their appointment telephone number, and posters for the lobby and exam room.

Joining together with QID in this effort is a group of physicians representing organizations such as the Delaware Academy of Family Physicians, the Delaware Chapter of the American College of OB/GYN, the American College of Physicians, as well as recognized leaders and experts in the diagnosis and treatment of breast cancer from across the state. This group has been joined by the American Cancer Society and the Delaware Division of Health and Human Services. We are particularly honored by the continuing support of the Honorable Ruth Ann Minner, Lieutenant Governor of Delaware (who served two years ago as our spokesperson for a mammography campaign in Kent County.) My thanks to each of these volunteers for their time and effort in making this issue of the *Delaware Medical Journal* possible. Their names appear elsewhere in this issue.

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If you have not received one of the QID's free mammography tool kits, or you would like more information regarding screening of Medicare patients, please call QID at 302-655-3077.

"Help Us Save Your Life"

Ruth Ann Minner

Breast cancer is a serious problem among senior women both here in Delaware and across the United States. According to the Centers for Disease Control, this year more than 180,000 American women will be diagnosed with breast cancer. In addition, more than 46,000 women nationally, and an estimated 75 women over the age of 65 in Delaware, will die of the disease. This is twice the rate of younger women.

Each woman who dies of breast cancer is too important to those around her as a wife, or sister, a mother or grandmother, a family member or friend to become part of these statistics. Breast cancer must be stopped.

If it is detected early, before it spreads, breast cancer can be stopped. With detection, the five-year survival rate for women who are treated is

Ruth Ann Minner is Lieutenant Governor of the state of Delaware.

93 percent. And the best way to detect breast cancer early is with regular mammograms. Medicare will help pay for mammograms every year. For women who qualify and need financial assistance with studies, the Breast and Cervical Cancer Early Detection Program is available.

The problem is that many women don't know about the importance of mammograms or that they may have their mammograms paid for.

In 1997, I was proud to collaborate with the West Virginia Medical Institute (now, Quality Insights of Delaware). We sent a letter to more than 8,000 senior women in Kent County warning of the dangers of breast cancer and urging them to get mammograms.

Do you know what? It worked.

Later research by WVMi (QID) showed that there was a noticeable and significant increase

in the number of mammograms done after the letter was distributed. Women will act when they hear about the necessity of mammograms.

Nationally, the same thing is true. In 1988, the rate of breast cancer deaths per 100,000 women was 27.5. According to the American Cancer Society, in 1998, the rate was 25.5. The Society credits the increased use of mammograms for the change.

We are getting the message out and must continue to do so.

I urge you to join with me in promoting the awareness of breast cancer and the need for mammograms. It is a simple message that can have a profound result. Our message to older women is simply this: "Help us save your life."

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Current Imaging Modalities for the Diagnosis of Breast Cancer

Steven L. Edell, D.O. — Marc D. Eisen, B.A.

ABSTRACT

Although mammography still remains the gold standard for breast cancer screening and diagnosis, it typically cannot differentiate benign from malignant disease and is less accurate in patients with dense glandular breasts. This article is an overview of imaging modalities that have emerged to augment mammography and improve the accuracy of non-invasive breast cancer diagnosis. Ultrasound is currently used to differentiate breast masses and guide aspirations and biopsies. Magnetic resonance imaging has excellent sensitivity in demonstrating breast cancer but a low specificity. Nuclear medicine studies have recently emerged that detect the increased metabolic rate and vascularity of breast cancers. Other modalities, such as thermography and computed tomography, have a more limited utility for breast cancer diagnosis. Digital mammography is among other emerging technological advancements that will continue to develop and improve the accuracy of breast cancer diagnosis in the future.

INTRODUCTION

Breast cancer is the most common malignancy diagnosed in women and will cause approximately 44,000 or 16 percent of all cancer deaths in American women in 1999.¹ The most effective method for reducing breast cancer mortality is early detection and treatment of disease.² Although mammography still remains the gold standard for breast cancer diagnosis, it has significant diagnostic flaws. While mammography is sensitive for detecting breast abnormali-

ties, it typically cannot differentiate benign from malignant disease. As a result, the positive predictive value of mammography in demonstrating malignancy, which is the fraction of biopsies that yield malignancy, has been reported as less than 30 percent for nonpalpable cancers.³ Furthermore, mammographic densities that are common presentations of malignancy are often obscured in patients with dense glandular breasts or implants, making detection extremely difficult (Figure 1).⁴ For these reasons, other imaging modalities have emerged as an adjunct to the mammogram in an attempt to improve the diagnostic accuracy of demonstrating cancers in dense or in heterogeneously dense breasts. These include ultrasound, computerized tomography (CT), magnetic resonance imaging (MRI), and nuclear medicine techniques. This article focuses on these modalities and briefly discusses newer, emerging breast imaging technology.

Steven L. Edell, D.O., is Medical Director of the Women's Imaging Center, Delaware Spect Imaging Center, and Delaware Open MRI, all of Newark, Delaware. His interests include mammography and emerging nuclear medicine techniques in breast cancer imaging.

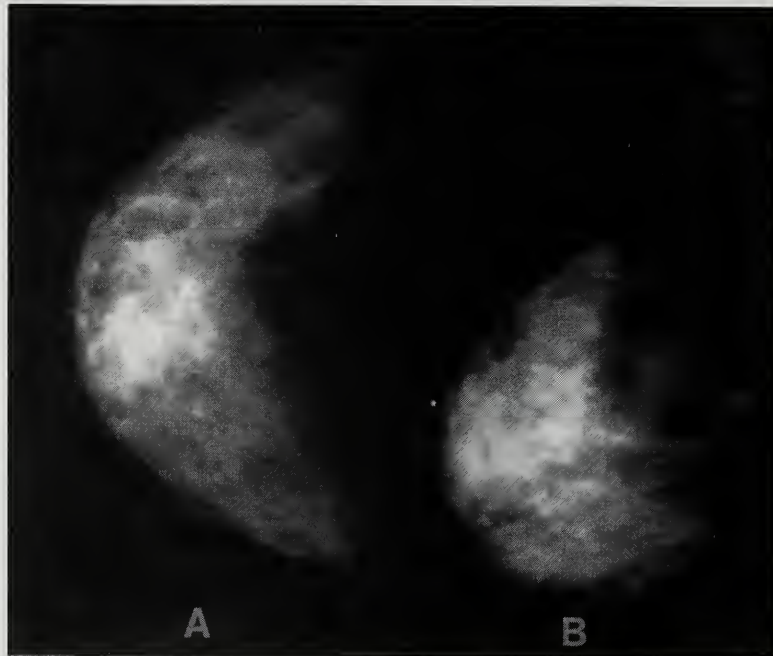
Marc D. Eisen, B.A., is currently a medical student at the University of Pennsylvania. In addition to his medical studies, he is pursuing a doctorate degree in Neuroscience as a Franklin scholar.

ULTRASOUND

Ultrasound has long been proven an effective study to differentiate between cystic and solid masses but has never gained wide acceptance as a universal screening procedure for demonstrating breast cancer. Ultrasound utilizes the transmission of high frequency sound waves and the evaluation of returning sound to recognize abnormalities in the breast parenchyma. Ultrasound is used predominantly to further evaluate mammographic abnormalities or palpable masses.⁵ Ultrasound can differentiate cystic from solid masses with nearly perfect accuracy with newer, more sophisticated high-resolution transducers. Unfortunately, the specificity of demonstrating a cancer within a solid mass has been disappointing and, hence, most solid masses observed by ultrasound must be biopsied to rule out malignancy. Furthermore, a negative ultrasound in patients with a palpable mass cannot be used to exclude malignancy, as noninvasive or diffuse tumors may be invisible to ultrasound. Nonetheless, when ultrasound is used in conjunction with mammography, breast cancer can be diagnosed with sensitivity and specificity of 92 percent and 98 percent, respectively.⁶

Ultrasound is also a proven aid to breast cyst aspiration and mass biopsy. Prior to ultrasonic guidance, a radiologist could aspirate a cyst or biopsy a mass only by palpation, as the procedure was done blindly. Ultrasonic guidance now allows visualization of the lesion during the procedure, permitting the radiologist to confirm the needle's placement within the lesion and directly observe fluid aspiration or mass biopsy. Color flow and power Doppler high resolution sonography have continued to improve visualization of blood flow, improving the detection of tumor angiogenesis in solid masses.⁷

Figure 1: Mammogram demonstrating dense breasts in craniocaudad (A) and mediolateral oblique (B) projections.



MRI

Magnetic resonance imaging (MRI) is a highly sensitive non-ionizing modality that utilizes high strength magnetic waves to visualize the morphologic features of soft tissues with millimeter resolution. MRI can detect tumors as small as one to two mm with a sensitivity approaching 100 percent.⁸⁻¹¹ MRI is not affected by dense breasts or implants and thus has the ability to demonstrate obscured mammographic abnormalities as well as small synchronous lesions within the same or opposite breasts of symptomatic patients. Thus, MRI has great potential to improve the diagnosis, staging, and surgical management of breast cancer (Figure 2).¹² The questionable clinical relevance of these MRI abnormalities that suggest breast cancer, however, remains to be clinically proven. Unfortunately the specificity of MRI in demonstrating breast cancers has been reported as low as 30-40 percent^{10,13} and may lead to unnecessary biopsies of false positive lesions.

Multi-institutional clinical trials are underway to improve the specificity of MRI utilizing dynamic imaging, three-dimensional fast imaging, and newer contrast-enhanced techniques which offer a promising future for MRI in breast cancer diagnosis.¹⁴

NUCLEAR MEDICINE

Nuclear medicine studies have also been proven and accepted as an adjunct to mammography in demonstrating breast cancer. Numerous radionuclide imaging techniques and radiopharmaceuticals have been developed, including technitium 99m (^{99m}Tc)-labeled compounds for planar or SPECT imaging, and those for positron emission tomography (PET), such as ¹⁸F-fluoro-2-deoxy-D-glucose (FDG). Technitium 99m-labeled compounds show an affinity for tissues with increased metabolic activity and perfusion.¹⁵ ^{99m}Tc-sestamibi (Miraluma®, Dupont Pharmaceuticals) has emerged as the most successful of these compounds for breast cancer detection. The isotope was originally used for

myocardial stress studies because it localized in the mitochondria-rich left ventricle. A left ventricle diseased by ischemia or infarction thus demonstrated less activity in the affected area. During a ^{99m}Tc-sestamibi myocardial stress exam, Rambaldi et al serendipitously found a focal area of increased activity in a patient's left breast that was subsequently proven to be a breast cancer.¹⁶ Additional studies have shown that ^{99m}Tc-sestamibi scintimammography can detect breast cancer with an average of 85 percent sensitivity and 89 percent specificity.^{15,17,18} Like MRI, the advantage of ^{99m}Tc-sestamibi scintimammography over conventional mammography is its ability to demonstrate a breast cancer in the mammographically dense breast or in patients with breast implants (Figure 3). Compared to MRI, however, ^{99m}Tc-sestamibi scintimammography has shown a significantly higher specificity.¹⁹⁻²¹ Sestamibi scintimammography has thus become a more accepted adjunct to the dense mammogram, especially for patients with a palpable mass that cannot be identified mammographically.²² The major disadvantage of nuclear medicine imag-

Figure 2: Post-contrast T1-weighted gradient 3-D echo MRI with subtraction of pre-contrast image from post contrast image demonstrating invasive ductal carcinoma (arrow) and skin metastasis (arrowheads).

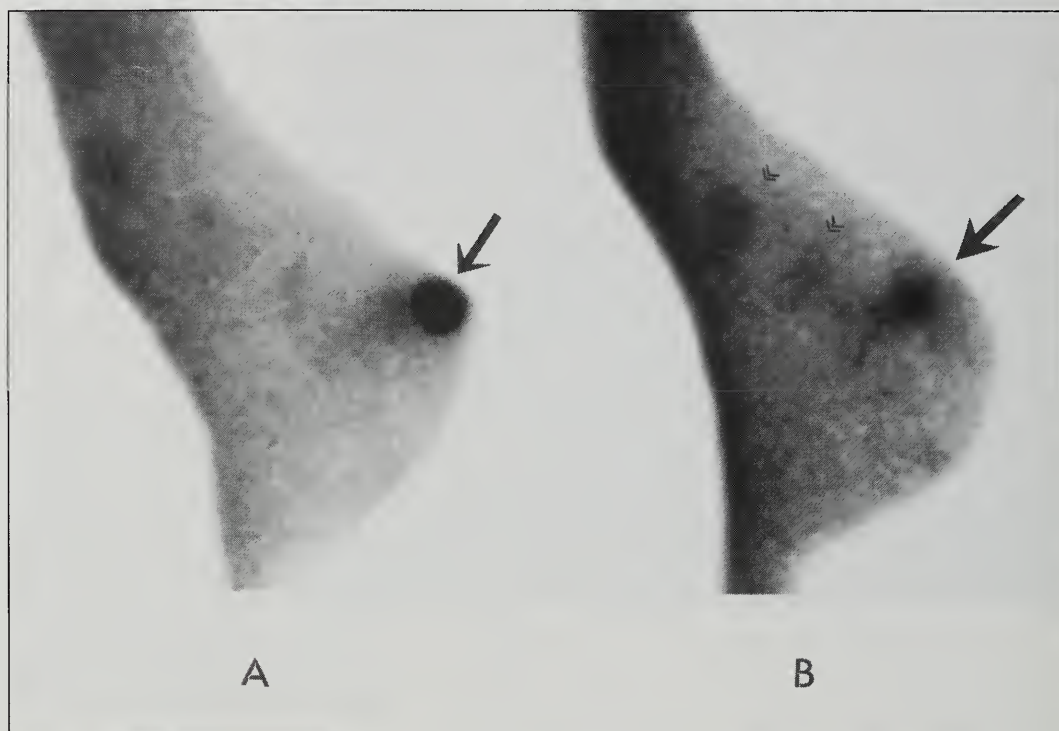


ing, however, is its poor resolution for demonstrating cancers smaller than one-cm.²³ This limitation precludes its use as a universal breast cancer-screening modality. In the future, technological advancements for nuclear medicine imaging, including digital solid state detectors, will improve its resolution and may lead to wider clinical acceptance.

Positron Emission Tomography (PET) scanning with 2- ^{18}F Fluoro-2-deoxy-D-glucose (FDG) has also gained increasing popularity in recent years in differentiating benign from malignant breast masses as well as evaluating local and distant metastasis. Like $^{99\text{m}}\text{Tc}$ -sestamibi scintimammography, PET imaging successfully dem-

onstrates tumors in the mammographically dense or surgically altered breast.²⁴ An advantage of FDG over $^{99\text{m}}\text{Tc}$ -sestamibi is its ability to image increased metabolic activity characteristic of malignant rather than benign lesions.²⁵⁻²⁶ Additionally, whole body PET imaging can be used to detect widespread metastasis as well as axillary nodal involvement.²⁷ Detecting metastasis may be helpful in following a patient's response to chemotherapy and managing future treatment.^{24,28} Limitations of PET scanning have been the high cost and availability of the system and the cyclotron-produced isotope FDG needed for imaging, which have limited the system mainly to large university settings. Once again, the resolution of nuclear imaging currently renders lesions less than one-cm difficult to image with PET. Future developments of PET include less expensive, more commercially-available systems and cost-effective, improved availability of FDG.

Figure 3: Scintimammogram from patient in Figure 1. Left image (A) shows marker (arrow) of patient's palpable mass not demonstrated on conventional mammography. Right image (B) shows marker removed and focal uptake representing underlying tumor (arrow). Additionally, two unsuspected synchronous tumors (arrowheads) are identified.



THERMOGRAPHY

Thermography has failed to gain any popularity as a breast imaging modality. This examination detects temperature gradients within the breast parenchyma, demonstrating tumors because of their increased vascularity. Unfortunately, numerous benign entities result in focally increased heat, producing a high false positive rate. This imaging study, although utilized in the 1970s, is now rare. More recently, clinical trials are in progress that use advanced computerized thermographic units in an attempt to reduce the false positive rates and increase specificity. With these improvements, use of thermography may re-emerge as a useful diagnostic modality.

CT

Computed tomography (CT), which utilizes x-ray beams in a tomographic three-dimensional setting, has limited ability to demonstrate benign versus malignant lesions. Due to its greater examination time, increased radiation, and higher cost than conventional mammography, the utilization of CT has found little success in breast cancer diagnosis. However, like ultrasound, CT has gained acceptance in directly guiding the radiologist to a mammographic abnormality during biopsy.

FUTURE APPLICATIONS

Digital Mammography. Standard mammography captures transmitted x-rays on a film screen, which the radiologist then examines directly. New technology, however, offers the opportunity to capture the x-ray image digitally, that is with a fine array of detectors that together yield an image viewed on a computer screen. Digital images allow the radiologist to "window" the image, a means of adjusting the image's contrast, in order to detect subtle details that may be missed by the fixed, limited contrast of film-screen mammography.²⁹ Digital imaging also offers the possibility of image processing techniques that would automate the detection of breast abnormalities. Computer-assisted diagnosis, as it is called, does not replace the discretion of the radiologist, but it has been shown to improve the detection of microcalcifications.³⁰ Digital mammography remains experimental, and its cost continues to exceed that of film-screen mammography. Furthermore, the increased sensitivity of digital mammography may increase the number of false positive studies and unnecessary biopsies. However, as this technology continues to improve, digital mammography will definitely play a large diagnostic role in the future.

Digital tomosynthesis acquires computerized breast images from multiple angles and then reconstitutes the data to decrease the noise produced by dense normal glandular tissue, improving the accuracy of cancer detection in

mammographically dense breasts.²⁹ Other newer breast imaging techniques, such as laser-enhanced mammography, three-dimensional breast imaging, dual energy subtraction, and thermoacoustic CT are still in technical development stages.

CONCLUSION

In conclusion, conventional mammography continues to remain the gold standard for breast cancer screening, despite its limitations. Ultrasound, scintimammography, and MRI are currently useful adjuncts to the mammogram, especially in the mammographically dense breast or in evaluating palpable masses not detected mammographically. Until we find the "Holy Grail" of breast cancer detection, we must still strive to develop other imaging modalities to enable us to find breast cancer at its earliest stages.

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Screening for Life: Helping Delaware Women Receive Lifesaving Services

Romie Lutz

Since August 1997, the Division of Public Health has enrolled more than 1,100 women in its Screening for Life program. Funded by the Centers for Disease Control, this program is part of a national initiative which focuses on the early detection of breast and cervical cancers.

The Screening for Life program is available to all uninsured or under-insured women, age 40 or older, having an income less than 250 percent of the federal poverty level (a single woman earning approximately \$20,000 per year would qualify). For eligible women, Screening for Life pays all or part of the cost for mammography and other screening services; yet, there are as many as 8,000 women in Delaware who qualify

for these services, but are not receiving them. We need your help in reaching this high-risk population.

Currently, more than 100 health care providers, including private physicians, primary health care centers, hospitals, outpatient clinics, mammography facilities and laboratories, are participating in the program. Paid on a fee-for-service basis, these providers offer mammograms, papsmears, pelvic exams, clinical breast exams, and other services to Screening for Life patients.

If you are not already participating in the Screening for Life program, here's how you can help:

- **Join the Screening for Life network of providers.** Primary care physicians, OB/GYNs, and surgeons are needed to increase the accessibility of screening services state-

Romie Lutz is director of Screening for Life, a program of the Delaware Health and Social Services' Division of Public Health. For information about becoming a provider or obtaining free educational materials, please call Ms. Lutz at 302-739-4651.

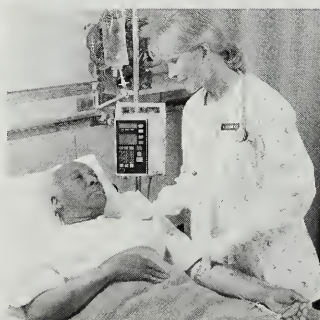
wide. Low-income women are more likely to seek these services if they can gain access to them through a provider in their own community.

- **Spread the word.** You may already be serving patients who qualify for the program. If they do not have insurance to pay your fees, have a high insurance deductible, or cannot afford the full range of screening services they need, tell them about Screening for Life. The program may be able to

help pay the bill. *Eligibility is determined on a case-by-case basis.*

- **Make Screening for Life materials available.** Screening for Life can provide you with informational program brochures and posters for display in your office.

By participating as a provider or spreading the word about the Screening for Life program, you can help us reduce the mortality and incidence rates of breast and cervical cancers in Delaware.



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Early Detection Reminder Systems A Boon for Cancer Screenings

Judy Dolinger

Primary care physicians, and their staffs, play a crucial role in ensuring patients receive early detection screenings. For this reason, a one-year pilot program, the Primary Care Liaison Project, was developed. Funded by the American Cancer Society, Delaware Council and the Division of Public Health's Breast and Cervical Cancer Screening Project, (Screening for Life), this program will assist Delaware primary care practices in identifying patients who should be receiving specific gender and age-appropriate cancer screenings and information.

The program has hired a nurse practitioner who is responsible for contacting and visiting at least 24 primary care practices in the state during the year. These one hour breakfast or lunch meetings will enable the Primary Care Liaison to help each practice assess their level of

performance in using early detection reminder systems in their office. She will be able to offer practices a software tracking system (Practice Partners from Medcom) that can identify patients who have not had their yearly exams. This system will be able to send reminder letters to patients who have not had their mammogram and/or PAP test, those who are due for a prostate or colo-rectal exam, or patients needing other age appropriate testing. These reminders can be particularly important in the breast cancer screening of an older patient who is not coming in regularly, but may be seeing specialists more frequently than the primary care doctor.

For those practices without the requisite computer hardware, the Primary Care Liaison will offer a comprehensive resource notebook. The notebook includes the American Cancer Society guidelines for early cancer detection, plus Medicare coverage and other resource information. The notebook also includes

Judy Dolinger is a member of the American Cancer Society - Delaware Council.

brochure samples detailing some common cancers (brochures can be ordered from the American Cancer Society) as well as resources for free and low cost screening for breast and cervical cancer detection.

The Connecticut Division of the American Cancer Society piloted this program over two years ago, without the software package. They feel that by helping primary care practices identify strengths and weaknesses in their early

detection screening methods, many have implemented some of the ideas discussed at the visit or improved their present system for identifying patients who need cancer related checkups. The American Cancer Society in Delaware is hopeful that by offering various types of reminder systems, primary care practices can not only improve their methods of identifying patients who need specific cancer-related checkups and other screening tests, but that they can do it in an easy and timely manner.

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Drugs Can Reduce the Incidence of Breast Cancer: Now What?

Timothy F. Wozniak, M.D. — Pamela G. Eppes, R.N., M.S.N., O.C.N.
Clare T. Wilson, R.N., M.S.

BACKGROUND

The P-1 trial of the National Surgical Adjuvant Breast and Bowel Project (NSABP) showed that the incidence of invasive breast cancer can be reduced by 49 percent. Women deemed to be at sufficient risk for developing breast cancer in five years, as defined by the study to be 1.66 percent or greater, were evaluated. Six thousand women treated with tamoxifen had 86 fewer invasive breast cancers, 34 fewer non-invasive breast cancers, 27 fewer fractures, but 21 more uterine cancers and 38 more thromboembolic events with two deaths from pulmonary emboli (all events were statistically significant).

The results of the trial have produced more interest among physicians than women at risk

Timothy F. Wozniak, M.D., is the Principal Investigator for the Christiana Care Health Services Star Study. Pamela G. Eppes, R.N., and Clare T. Wilson, R.N., are Study Coordinators.

despite direct advertising for tamoxifen on television and print media. Many gynecologists and primary care physicians are suggesting drug therapy to their patients who have had positive family histories for breast cancer, a diagnosis of atypical lobular hyperplasia, or other risk factors.

Another drug, raloxifene, has been shown in similar studies to reduce breast cancer incidence, perhaps without the increased risk of uterine cancer. Currently it is approved only for treatment of osteoporosis. It is a drug with a smaller worldwide experience, yet is quite similar to tamoxifen being a SERM (Selective Estrogen Receptor Modulator). The rapid rise of this new medication, its apparent favorable toxicity profile, and miraculous effectiveness parallels the history of tamoxifen, which had a similar early profile with only later recognition of an increase in uterine cancer.

DISCUSSION

What are the considerations a physician must entertain when discussing or recommending pharmacologic breast cancer prevention. These considerations are 1) the magnitude and scope of benefit, 2) the magnitude and scope of toxicities, 3) the careful assessment of the patient's breast cancer risk and expectations of treatment, and 4) the treatment choices.

Tamoxifen can reduce the risks of invasive breast cancer by 49 percent. In the trial, which on average included women with a risk of 6.49 percent per five years, only 3.58 percent of women developed invasive breast cancer. Non-invasive cancer was also reduced. As an added benefit of tamoxifen, hip fracture risk was cut in half due to reduced osteoporosis in the treatment group. Despite three fewer deaths from breast cancer during the trial in the tamoxifen group, the figures were too small to guarantee an overall survival benefit.

Tamoxifen therapy is not risk free. The life threatening disadvantages were an increased risk (RR 2.53) of uterine cancer in the treatment group over placebo group. All uterine cancers in diagnosed patients were Stage I. One death occurred from a Stage IV patient in the placebo group. SERM therapy was associated with a 3x risk of pulmonary embolism and 50 percent increased risk of deep venous thrombosis and cerebrovascular accident. There were two deaths from pulmonary embolism in the tamoxifen treated group in the P-1 trial. Both thromboembolic disease risk and uterine carcinoma risk, it must be remembered, increase independently with age. The nonlethal adverse events are not as dramatic but may be troubling. Hot flashes are increased in all age cohorts and are rated bothersome in over 17 percent. There is a small increase in the annual rate of cataracts (Relative Risk 1.14).

Evaluation of the patient's individual risk is critical. The targeted risk for entry into the P1 study was 1.66 percent over five years, near the risk of a woman 60 years old without any other risk factors other than age and sex. Calculation

in the P-1 study was accomplished with the Gail formula, which factors in age, family history, age at menarche, age at first live birth, race, and biopsy history. But such a numerical assessment does not always correlate with perceived risk; a specific numerical risk may have a much greater impact for the younger women than it does to older patients. It is harder to quantitate the thromboembolic and uterine cancer risk as no models exist to predict this type of risk. When a woman perceives a close family member dying of strokes or pulmonary emboli, breast cancer may be the lesser threat.

The FDA approved choice of pharmacologic therapy for breast cancer prevention at present is tamoxifen. Raloxifene is not approved by the FDA for breast cancer prevention despite preliminary favorable evidence. Raloxifene is, however, available in the P-2 trial (STAR—Study of Tamoxifen and Raloxifene for the Prevention of Breast Cancer).

Raloxifene, it is hoped, will not be associated with increased uterine cancer risk, but it appears to have similar thromboembolic risks. Raloxifene has not been tested in women similar to those in the P-1 trial. How is a Delaware physician to proceed? My suggestion to all physicians is to refer to the STAR trial for all postmenopausal patients. The trial provides a risk assessment for breast cancer as well as an estimate of adverse events. The enrollment and informed consent process precisely educates the physician and patient regarding the risks and benefits of therapy. Premenopausal patients may become eligible in the near term (one year) when a safety profile for raloxifene in the premenopausal patient is available. If a woman is premenopausal and has a risk of over 1.7 percent, discussion of tamoxifen therapy should be entertained earlier. In this group of young women withholding treatment until eligible for the STAR trial may be acceptable but not, in my judgment, without a careful explanation of tamoxifen therapy risk/benefit.

Delaware is fortunate to be covered north and south for enrollment into the STAR study.

Physicians wanting more information on the STAR trial or wanting to refer a participant for the study may contact one of the following:

New Castle County

Christiana Care Health System
Cancer Research Office
Telephone# 302-733-6227

Contact person(s):

-Pamela G. Eppes, RN, MSN, OCN

-Clare T. Wilson, RN, MS

Kent County:

See New Castle County or Sussex County

Sussex County:

Beebe Medical Center
Telephone#302-645-3310

Contact person:

-Joy Bartell, RN, BSN

Nanticoke Memorial Hospital

Telephone#302-629-0260

Contact person:

-Nancy Whelan, RN

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Proceedings of ASCO, Volume 17, 1998.



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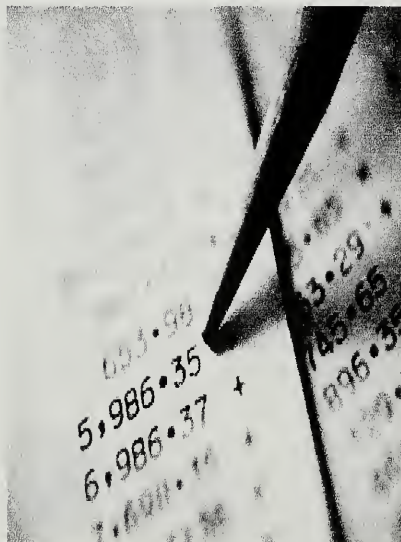
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SLN Biopsy in Breast Cancer: Christiana Care Experience May 1998 - February 1999

Diana Dickson-Witmer, M.D., F.A.C.S. — Dennis R. Witmer, M.D., F.A.C.S.
Jennifer Hornung, P.A.

INTRODUCTION

In patients with breast cancer, axillary lymph node dissection (ALND) remains the standard of care. Complete nodal dissection for breast cancer, however, has significant morbidity, with 8-20 percent of patients developing lymphedema. Despite the procedure's potential risks, ALND continues to be used for patients with invasive breast cancer because it affords improved local control, and because nodal status continues to impact treatment decisions that affect survival.¹

No imaging studies, tumor marker or combination of markers accurately predict nodal status or systemic recurrence of breast cancer as well as ALND. Though chemotherapy is currently recommended for all patients with invasive breast

cancers one-cm or larger regardless of nodal status, nodal status remains the single most powerful predictor of recurrence and survival. The presence of nodal metastases decreases five-year survival by 40 percent. Nodal status is also useful in selecting specific regimens of chemotherapy in patients with tumors greater than one-cm.² This article reports on a study of 53 consecutive patients with invasive breast cancer who underwent sentinel lymph node (SLN) biopsy and ALND at Christiana Care Health System between May 1998 and February 1999.

SLN biopsy is a promising alternative to routine ALND. This more sensitive method of detection may not only be practical and cost-effective, but it can also significantly decrease surgical morbidity in 70-80 percent of breast cancer patients.³ SLN biopsy for breast cancer offers the advantages of identifying patients who truly have nodal metastases while sparing others the need for ALND or radiotherapy. Sentinel lymph

All authors are members of the Department of Surgery at Christiana Care Health System in Wilmington, Delaware.

node biopsy may provide an even greater benefit than decreased surgical morbidity; some data suggest the procedure may help prevent understaging of breast cancer patients.⁴

Several studies have indicated that current routine histologic examinations of regional lymph nodes may underestimate breast cancer metastases.⁵ As early as 1948, Saphir and Amromin demonstrated that standard H&E evaluation of axillary lymph node specimens understaged breast cancer patients 33 percent of the time.⁶ They reported that serial sectioning of nodes from 30 patients previously found node-negative revealed metastases in ten patients. More recently, when Dr. David Winchester at Northwestern used serial sectioning at 150-micrometer intervals and a cocktail of anti-keratin antibody stains to evaluate nodes from 86 patients previously thought to be node-negative, 12.8 percent were upstaged by finding metastases. Dr. Winchester further evaluated the 86 patients for differences in outcome. Five-year disease specific survival was 95 percent for node-negative patients and only 90 percent for those with occult metastases in nodes.^{7,8} Dr. Harris wrote, regarding "micrometastases" in axillary lymph nodes, "similar to the findings with serial sectioning, the results using immunohistochemical staining indicate the following: (1) that the histologic involvement of axillary nodes can be detected in 10-20 percent of invasive ductal carcinoma cases judged to be node-negative by routine staining with hematoxyline and eosin, and (2) that such involvement suggests a slightly worse prognosis compared with patients without involvement."⁹ A study at the Royal Victoria Infirmary in the United Kingdom re-reviewed 343 patients using antimucin monoclonal antibodies. Twelve percent of patients judged node-negative by routine H&E were found to have metastases in their nodes. The five-year recurrence rates were 17 percent for true node-negative patients and 46 percent for patients with occult metastases in two or more nodes.¹⁰

The fact that we are understaging many patients with invasive breast cancer is borne out by the 15 percent five-year mortality rate among

Table 1: Protocol of SLN Study

Step 1	450 microcuries of filtered technetium sulfur colloid injected peritumoral 4 hours before surgery
Step 2	3-5 cc of isosulfan blue injected peritumoral 10 minutes before surgery
Step 3	Frozen sections performed on each SLN
Step 4	Complete levels I and II ALND on every patient

patients found to be node-negative by routine methods of evaluating the axillary lymph nodes.¹¹ Therefore, chemotherapy remains the standard recommendation for patients with invasive breast cancer one-cm or larger, despite nodal status. There are, however, good reasons why serial sectioning and immunohistochemistry (IH) cannot be routinely used. The techniques are costly and labor-intensive.¹² In Dr. Winchester's study of 86 patients, only 20 of 900 slides stained with anticytokeratin antibody had metastatic deposits.

SLN biopsy may offer a solution to this dilemma. Standard ALND removes 10 to 30 nodes, SLN biopsy, one to three. The smaller volume of tissue allows a more focused histologic exam with serial sections and immunohistochemistry done on the nodes most likely to contain disease. Special techniques can easily be applied for focused analysis of one or two sentinel nodes but are impractical if not impossible for the entire axillary contents. Dr. Giuliano has shown that SLN biopsy with IH is more sensitive than ALND levels I and II with H&E in the detection of axillary metastases. In his series of 103 patients, he found that SLN biopsy with H&E and IH upstaged 14 percent of patients relative to ALND with H&E.¹³

SLN biopsy for breast cancer may, therefore, prevent undertreatment of patients with tumors smaller than one-cm by detecting metastases that might have been missed with ALND alone. Also, SLN biopsy may help prevent overtreatment of some node-negative patients with tumors larger than one centimeter. Dr. Giuliano has written, "I can envision looking at tumor factors, sentinel node, bone mar-

row and various different techniques, including perhaps PCR [polymerase chain reaction], to identify the truly low-risk, node-negative woman who does not need systemic therapy at all.”³

BACKGROUND

In Paraguay in the 1970s, Dr. Ramon Cabañas was performing lymphangiograms through the dorsal lymphatics of the penis in 100 penile carcinoma patients when he determined that drainage was always first into a specific lymph node. This “sentinel lymph node,” near the superficial epigastric vein, was found to contain metastases in all patients whose carcinoma had metastasized. As Cabañas reported in *Cancer*, “Anatomically, clinically, and pathologically, it was found that the SLN is the first site of metastases and may be the only lymph node involved.”¹³ Thus the SLN was the first filter in the penile lymphatic pathway. Among 46 cases in which Cabañas performed SLN biopsy, 15 were positive. In 12 of these cases, the SLN was the only positive lymph node in the inguinal, femoral, or iliac nodal dissection.

Dr. Cabañas undertook his sentinel node project in an attempt to spare his patients the tremendous morbidity associated with extensive lymph node dissection. Dr. Morton proposed sentinel node biopsy as a partial solution to this problem and to the problem of determining which nodal basin to dissect for melanoma.¹⁴ In the 1990s, Morton developed a method of identifying the first node filtering lymph drainage from cutaneous melanomas. Like Cabañas, he called this the sentinel node. Because the sentinel node is the first node to receive lymphatic drainage from a primary tumor, it is the first node to which a tumor will metastasize. Morton designed a prospective study to prove that if the sentinel node is negative for metastatic disease, the remaining nodes in the lymphatic basin are also likely to be negative. In his series, SLN biopsy for melanoma was 100 percent predictive of nodal status. Recurrences in undissected basins after negative SLN biopsy oc-

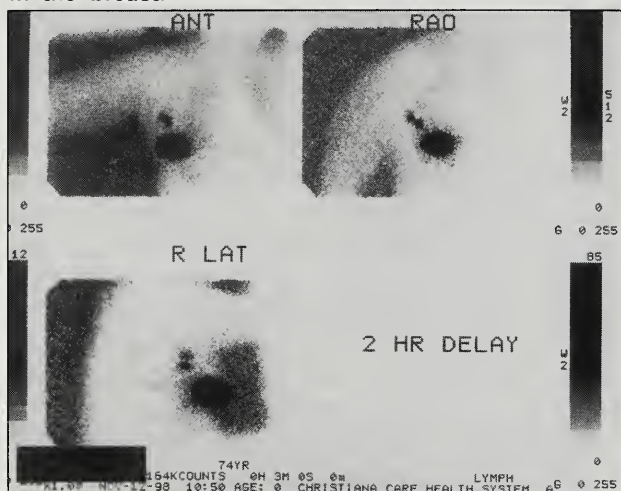
curred in only 4.1 percent of cases.¹⁵ Because nodal staging for melanoma patients by means of SLN biopsy is an accurate technique with minimal morbidity, it has become the standard of care in melanoma.^{16,17}

It is not surprising that shortly after these findings were published, several researchers began to adapt the SLN biopsy concept to breast cancer.¹⁸⁻²⁸ In 1997, Drs. Giuliano, Reintgen and Krag in the United States, Dr. Veronesi in Italy, and others reported promising findings regarding SLN biopsy for breast cancer.¹⁸⁻²⁸ Giuliano published a study of 100 breast cancer patients in whom SLN biopsy produced no false-negative results and proved 100 percent effective as an axillary staging technique. Dr. Krag, in Vermont, published a multi-institutional study involving 443 patients. The SLN was located in 413 of these patients, but it accurately predicted nodal status in only 392 patients. This false-negative rate of 11.3 percent is considerably higher than the false-negative rate in many other single institutional studies. A false-negative rate is calculated by dividing the number of patients with a false-negative SLN (no tumor in SLN, but tumor elsewhere in axilla) by the number of patients with a positive ALND. The higher false-negative rate in Dr. Krag’s series may reflect the fact that his series used only radioactivity, without visible dye, to find the SLN. Drs. Cox and Reintgen, in Tampa, using both radioactivity and visible blue dye, studied 446 patients; 440 mapped (an SLN was identified). The false-negative rate was 0.99 percent. As mentioned above, in Giuliano’s series in Santa Monica of 107 patients, 100 mapped, and 100 were accurate, yielding a zero percent false-negative rate. Dr. Giuliano also used both

Table 2. Data Collected and Reviewed

1. All pathology reports
2. All operative reports
3. “Data collection sheets” (tumor size, location, mode of detection; dose and time of Tc99 injection; time of surgery; number of SLNs found, hot or blue or both, axillary level of SLNs found)
4. All preop lymphoscintigraphy films—personally reviewed by principal investigator (*Diana Dickson-Witmer, M.D.*)

Figure 1. Pre-op lymphoscintigraphy showing two sentinel nodes in axilla and one large injection site in the breast.



radioactivity and visible blue dye to find the SLN.

METHOD

In most centers, the SLN biopsy process involves the injection of a radioactive tracer and of a visible blue dye into breast tissue surrounding the tumor or excisional biopsy cavity. In some institutions, preoperative lymphoscintigraphy is used (see Figure 1). In the operating room, a hand-held gamma camera, sterile wrapped, is used to search out any nodes that have aggregated, radioactively labeled sulfur colloid particles. A three-cm incision and visual inspection are used to find blue-stained lymphatic channels and the node into which they drain (see Figure 2). An average of two sentinel nodes is immediately evaluated for tumor, either with touch prep or, more commonly, frozen section. In centers that have gone beyond the initial stages of development of this process, when tumor is not found in the SLN, the ALND is not done.

The first 53 consecutive patients undergoing SLN biopsy for breast cancer at Christiana Care Health System were studied under an approved Institutional Review Board protocol. All patients had

invasive breast cancer, and all had ALND whether or not tumor was found in the sentinel node. Each patient underwent lymphatic mapping with both filtered technetium sulfur colloid and the visible dye, isosulfan blue (Tables 1, 2). Three patients who did not fulfill the requirement of a complete axillary node dissection were dropped from the series.

RESULTS

Of the 50 patients remaining in the study, the SLN could not be identified in two, both of whom had large upper outer quadrant excisional biopsy cavities (Table 3). The mean number of nodes removed per patient was 15.78. In three of the 48 patients whose SLN could be identified, frozen section was negative, but permanent sections revealed tumor. The mean number of SLNs removed was 2.8 per patient, and the total number of lymph nodes removed was 789. Total positive SLNs numbered 15, and total positive non-SLNs numbered five. Seventy-six percent of the tumors were T1, 22 percent were T2, and two percent were multifocal. One patient had a clinically positive axilla prior to biopsy. Twenty-eight percent of the patients were node-positive (Tables 4-6).

Of the 48 patients in whom SLN was identified, only one had a false-negative. This was the patient with a clinically positive axilla preop-

Figure 2. Blue stained lymphatic vessels leading to blue stained sentinel nodes (2).

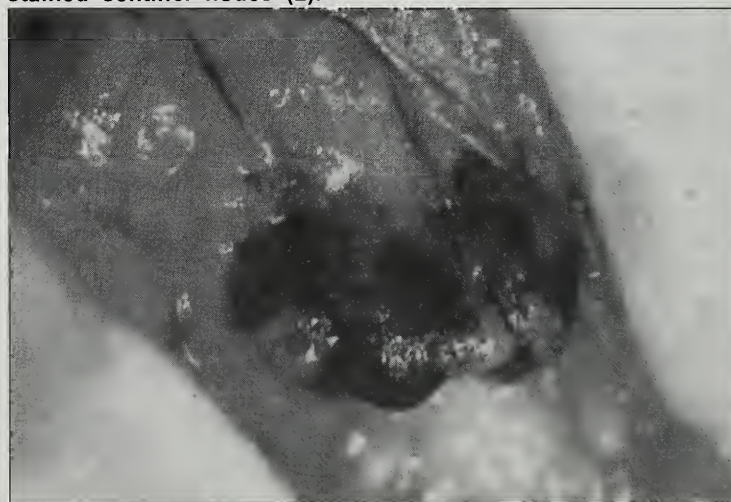


Table 3. Patients whose mapping did not identify SLN (2/50)

REASON
<u>Patient #2</u>
1200 microcuries Tc99m SC and large upper outer quadrant excisional biopsy cavity; huge shine-through
<u>Patient #34</u>
4-cm tumor in upper outer quadrant with large excisional biopsy cavity; huge shine-through

Table 4. SLN biopsy in breast cancer.

NUMBER	
Total Patients	50
Patients Who Mapped (SLN Identified)	48
Accurate Mappings	47
False-Negative Rate	7.1%
Total Nodes Removed	789
Nodes Per Pt (Mean)	15.78
Total SLNs Removed	135
SLNs Per Pt (Mean)	2.8
Positive SLNs	15
Total Non-SLNs	654
Total Positive Non-SLNs	5

eratively. Our false-negative rate was 7.19 percent. In most institutions, patients with clinically positive axillae are not considered for SLN biopsy. Dropping the patient with the clinically positive axilla from the series would bring the false-negative rate to zero percent.

DISCUSSION

Our study demonstrates that the results of SLN biopsy in a community hospital can approach the results of SLN biopsy in even the best of the single institutional series published. Guidelines are being developed to address when an individual surgeon should begin to drop ALND when the SLN is negative.²⁹ Both the American College of Surgeons and the American Society of Breast Surgeons have published guidelines recommending that, to accept the findings of SLN biopsy in lieu of ALND, an individual surgeon must show an 85-90 percent success rate at

Table 5. Intraoperative findings.

Pre-op lymphoscintigraphy concordant with intra-op findings	31 (62%)
No concordance	16 (32%)
Films missing, cannot be determined from nuclear medicine/op reports	1
Did not map pre-op	2
Failed intra-op mapping	2

Table 6. CCHS SLN Bx in breast cancer study 1998.

NO. OF PATIENTS WITH:	
Excisional biopsy	41 (82%)
Needle biopsy	7 (14%)
Unknown	2 (4%)
T1 lesion	38 (76%)
T2 lesion	11 (22%)
Multifocal lesions	2 (4%)
Positive nodes	14 (28%)
Negative frozen section of SLN, but positive permanent section	3

identifying the SLN and 90 percent overall accuracy in at least 30 consecutive cases of SLN biopsy, followed by complete ALND. The American Society of Breast Surgeons believes that such experience may be gained either as surgeon or first assistant³⁰ (Table 7). Several national protocols are currently evaluating the axillary recurrence rate following SLN biopsy alone and the feasibility of omitting ALND entirely, even when a positive SLN is found.

CONCLUSION

Current routine histologic examination of regional lymph nodes may underestimate nodal metastases in breast cancer, to the detriment of the patient. Serial sectioning and immunohistochemistry increase sensitivity but are too labor-intensive and expensive for routine use. The introduction of SLN biopsy in lieu of routine ALND holds promise for making serial section-

Table 7. Professional organizations' recommendations.

American College of Surgeons	American Society of Breast Surgeons
To enter the ACS SLN trial (which will drop ALND when SLN is negative: An individual surgeon must demonstrate a 90% accuracy rate in identifying the SLN, and a 90% staging accuracy in at least 30 consecutive cases of SLN biopsy followed by completion of ALND	- To accept the findings of SLN biopsy alone in lieu of axillary dissection, each surgeon should document an individual experience as surgeon or first assistant of ≥ 30 cases where both SLNB and ALND are performed - Experience should yield a $\geq 85\%$ success rate in identifying an axillary SLN - False negative rate of $\leq 5\%$ or single false negative SLN in the series

ing and immunohistochemical stains practical and cost-effective while decreasing surgical morbidity for most patients.

Our experience with SLN biopsy for breast cancer at Christiana Care Health System demonstrates that this technique can be performed in a community hospital with a 96 percent success rate in identifying the SLN and an overall accuracy of 97.9 percent in predicting nodal status in the axilla (Table 8).

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Table 8. SLN biopsy at CCHS - Statistics

VALUE	RESULTS	COMPUTATION METHOD
Positive Predictive	100%	Number of pts with positive ALND divided by the number of pts with positive SLNB = $14/13 \times 100 = 100\%$
Negative Predictive	100%	Number of pts with negative ALND divided by the number of pts with negative SLNB = $34/35 \times 100 = 97.1\%$
Sensitivity	92.9%	Number of pts with positive SLNB divided by the number of pts with positive ALND = $13/14 \times 100 = 92.9\%$
Specificity	100%	Number of pts with negative SLNB divided by the number of pts with negative ALND = $35/34 \times 100 = 100\%$
False Negative*	7.1%	Number of false-negative SLNB divided by number of pts with positive ALND = $1/14 \times 100 = 7.1\%$
Overall Accuracy	97.9%	Total number of true positive + true negative SLNB divided by number of pts with SLN identified = $47/48 \times 100 = 97.9\%$

*Single false-negative SLN biopsy was in patient with clinically positive axilla preoperatively, generally considered a contraindication to SLN biopsy; if this patient were dropped from study, false-negative rate would be 0%.

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On The Cover

Dante Gabriel Rossetti - Veronica Veronese c. 1872 (*Detail*)

Veronica Veronese was painted by Dante Gabriel Rossetti in London in 1872. Though not shown in its entirety on our cover, this magnificent work of art and its richly rendered details allude to the artist in the act of creation. The caged bird, a symbol for the unfettered soul, serves as the woman's inspiration in composing a piece of music. The sitter is Alexa Wilding, one of the "stunners" painted by the young Pre-Raphaelite artists such as Rossetti. Studio props Rossetti used in painting this work include the green velvet dress owned by Jane Morris, wife of William Morris and another "stunner," Indian silver jewelry, a Renaissance brocade (for the background), a fan that was in fashion at the time and musical instruments from Rossetti's own collection. The young British rebels who comprised the Pre-Raphaelite Brotherhood, intense, romantic and talented, stirred up Victorian society and changed English art forever.

Aesthetic Advances in TRAM Flap Breast Reconstruction: The Skin-sparing Mastectomy Technique

Christopher J. Saunders, M.D.

INTRODUCTION

Modern trends in breast reconstructive surgery have paralleled changes in surgical ablation of breast cancer. Just as general surgeons have added less deforming resections of breast tissue to their armamentarium, such as quadrantectomy and lumpectomy, so have plastic surgeons similarly evolved by adding new and improved techniques to reconstruct the breast. The main advances are in aesthetic refinements that improve the overall cosmetic result of the reconstruction.

The skin-sparing mastectomy technique is a reconstructive procedure where limited incisions are used to remove the breast cancer and

the axillary contents. Incisions can be limited to just the areolar area or an inverted "T" pattern. Autologous reconstruction of the breast with a transverse rectus myocutaneous (TRAM) flap is used to fill the skin envelope and complete the surgery. The aesthetic reconstruction of the breast is improved by minimizing or eliminating stigmata of surgery, such as visible scars, or "patch-like" skin patterns common after more conventional reconstruction. This retrospective review examines one plastic surgeon's experience with the aesthetic advances of skin-sparing mastectomy and TRAM flap reconstruction.

PATIENTS AND METHODS

Five patients ranging in age from 29 to 58 underwent skin-sparing mastectomy with immediate TRAM flap reconstruction. All patients had invasive ductal carcinoma stage I or stage II. There were no patients with stage III or

Christopher J. Saunders, M.D., practices plastic surgery and reconstructive surgery in Wilmington, Delaware. He is board certified in both plastic surgery and general surgery. He specializes in cosmetic surgery and aesthetic reconstructive surgery.

stage IV disease. Prerequisites for this procedure included a favorable biopsy site location, suitable donor tissue, and a skilled general surgery colleague for tumor ablation.

Surgical Design: The patients were marked preoperatively with planned limited incisions. The presence of significant ptosis or hypertrophy of either the affected breast or contralateral normal breast was addressed at the same operation. Inverted "T" incisions were used for skin-sparing technique where ptosis was to be corrected or breast hypertrophy was to be reduced. Periareolar incisions were used for breasts without hypertrophy or ptosis. If necessary, separate axillary incisions were used for removal of axillary lymph nodes. The most difficult aspect of the technique is flap elevation by the general surgeon. All tumor and breast tissue must be removed without damaging the blood supply to the skin flap or exposing dermis. Another critical factor is preservation of the inferior mammary crease. TRAM flap reconstruction was used to fill the resulting skin envelope. Skin islands were limited to just the nipple area when skin flaps were completely viable. Complete nipple areolar reconstruction was carried out at a second stage.

RESULTS

There were no instances of TRAM flap loss. Complications from surgery were unusual and minor. One patient had urinary retention. Another had cellulitis of the breast which responded to antibiotics. There were no instances of abdominal donor site complications. In one case, the periareolar technique led to poor skin flap perfusion and a standard reconstruction was performed. Another case utilizing the inverted "T" design had partial breakdown inferiorly that healed with dressing changes.

Hospital stays ranged from two to five days. Three patients had positive nodes and received postoperative chemotherapy. The adjunct treatment did not adversely affect the reconstruction. The postoperative follow-up period has been 1 to 30 months.

The aesthetic results of the reconstruction took into consideration the goals of breast reconstruction. Factors used to determine the aesthetic success of the operation included: the scars, extent of incisions, symmetry and shape compared to the contralateral breast, the presence or absence of "skin patches" characteristic of conventional techniques, and the location, shape, and size of the nipple areolar complex.

The author judged the aesthetic reconstruction as follows: two excellent, two good, one fair. Poor symmetry, and a less than ideal inferior mammary crease were the reasons for the one case judged as fair. Two cases had excellent aesthetic results with symmetric, minimally scarred, attractive breasts demonstrating the advances offered by skin-sparing technique. The four photographs demonstrate one patient judged as an excellent result. The patient had stage II left breast cancer. The patient had a skin-sparing mastectomy and TRAM flap reconstruction with simultaneous right breast reduction for slight hypertrophy and ptosis. The "nipple" on the left breast is actually the only part of the TRAM flap visible and is limited to the periareolar area. Formalized nipple reconstruction will be done at a second stage. (See Figures 1-4.)

DISCUSSION

The goals of breast reconstruction are to create a breast that is attractive in shape, size, and form with symmetry compared to the normal breast. Skin-sparing mastectomy and TRAM flap reconstruction offer improved aesthetic results compared with conventional techniques. The two main advantages include minimizing scarring (sometimes limited to the nipple-areolar complex) and the avoidance of the "patch-like" effect of skin flaps seen with conventional reconstructions. The overall improvement in the cosmetic appearance of the reconstructed breast can sometimes be dramatic. Known psychological advantage to patients with immediate breast reconstruction¹⁻³ should be enhanced by more aesthetic and attractive breast reconstructions offered by this skin-sparing technique.

Figure 1. The patient as seen preoperatively with left breast cancer.



Figure 3. The patient as seen preoperatively with left breast cancer.



Figure 2. The patient as seen postoperatively after left breast reconstruction. The nipple is to be reconstructed at a second stage. The TRAM flap is visible in only the areolar area.



Figure 4. The patient as seen postoperatively after skin-sparing mastectomy and TRAM flap reconstruction.



The surgical ablation of the tumor must not be compromised during the resection by the general surgeon in attempts to spare skin. The oncologic safety of the skin-sparing technique has been demonstrated in the literature.⁴ There is no evidence that these techniques increase local recurrence.⁵⁻⁷ It is believed that local recurrence is most related to the pathologic stage of the disease.⁸

The technical challenge to the ablative surgeon can not be overstated.^{5,7} The removal of the breast and tumor must be uncompromised and performed through limited incisions. Healthy and perfused skin flaps must be maintained for aesthetic reconstructions. The inferior mammary crease cannot be injured and must be maintained. If the tumor or other factors interfere with the preservation of these important aspects at surgery, conventional TRAM flap reconstruction can be done.

In summary, skin-sparing mastectomy technique and breast reconstruction can be performed, limiting scars and improving aesthetic results. The goals of reconstructing a breast perfect in shape, volume, and symmetry without scars are more closely realized with this technique.

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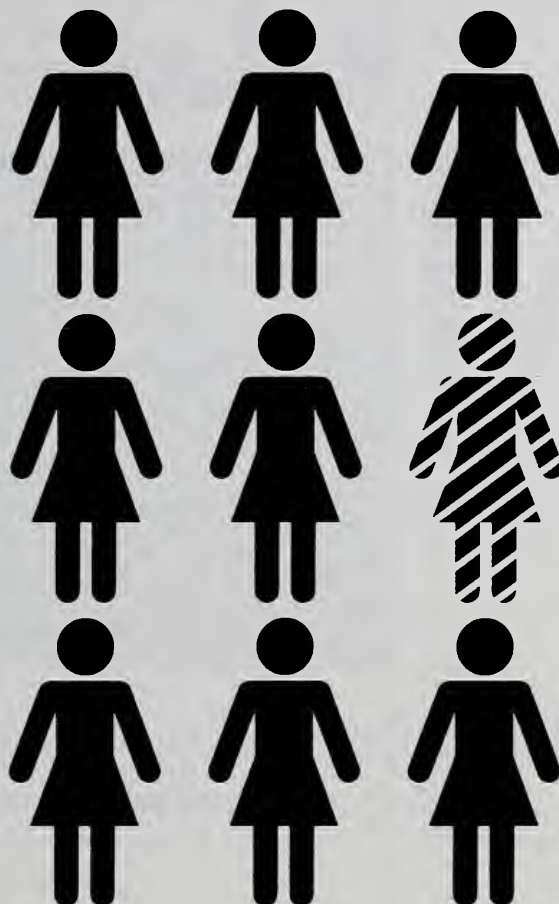
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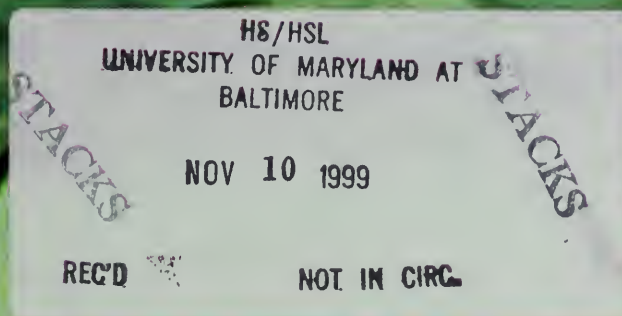
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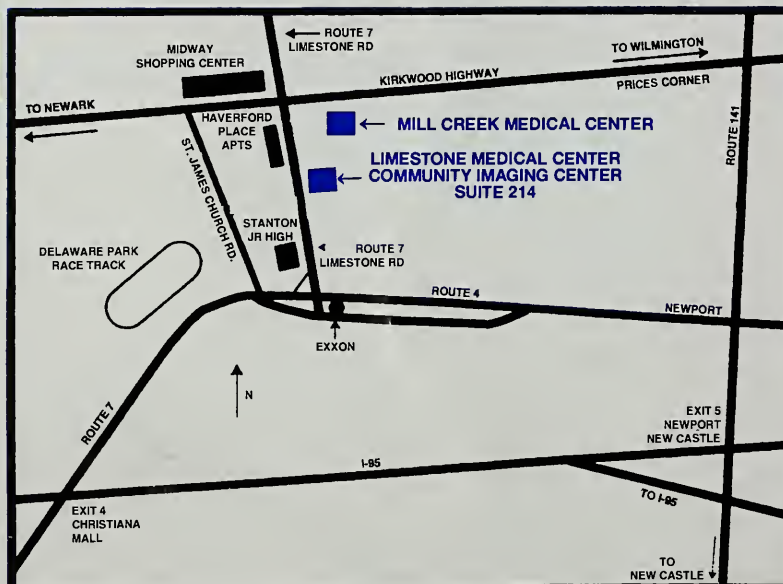
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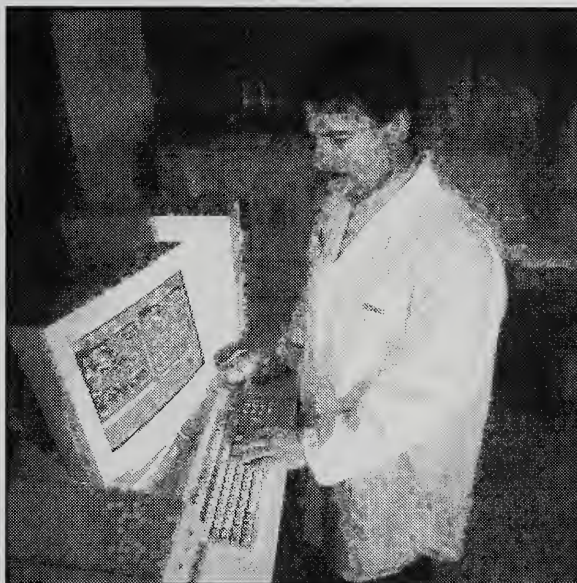
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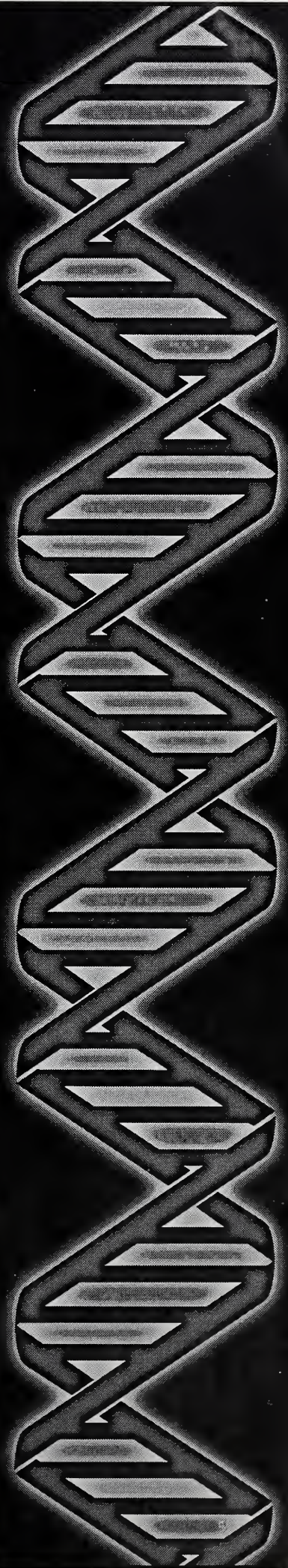
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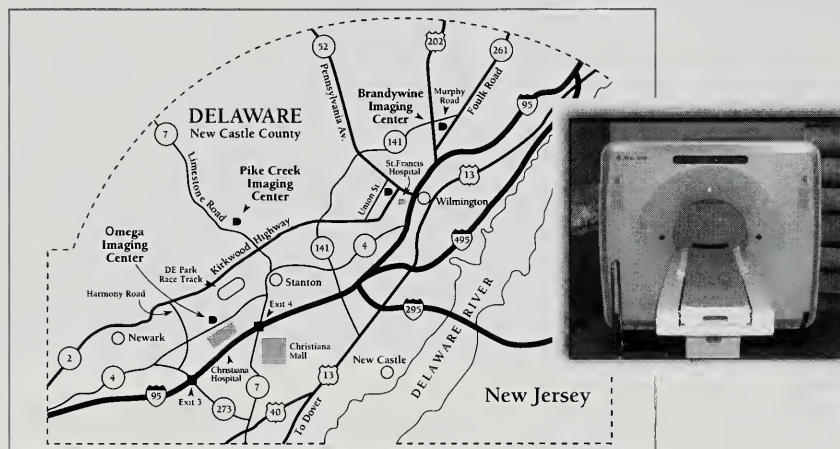
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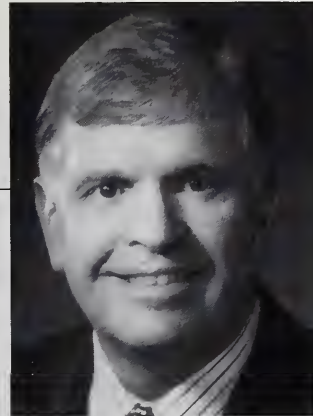
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Well Now, What About Men's Health?

Martin G. Begley, M.D.



There is no community of any size in Delaware, or in most of the country for that matter, that can't boast significant health programs and facilities devoted to women's health. Well now, where are the men's health centers?

This is a reasonable question as lack of men's health programs leaves a large segment of the population with significantly less opportunity for health education and access to preventive medicine and early disease detection programs than is available to the rest. Ironically, this situation has developed despite the fact that women's health programs have been so effectively promoted by practicing physicians and funded through leaders of public and private institutions, most of whom are men.

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, Delaware. He is the president of the Medical Society of Delaware.

To be fair, there are good reasons why this has happened. First, women are more health conscious and develop that quality early during their healthiest years. When pregnant, a woman seeks medical attention to protect her unborn child and is supported in doing so by her husband and the other men and women in her life. During this time she can develop working relationships with physicians, gain health awareness, and adopt the healthful habit of caring for herself. She can reinforce these relationships and habits accompanying her growing children for vaccinations, check-ups and treatment of inevitable childhood illnesses. Because of these experiences, women from across the country were ready to enthusiastically accept recent health care initiatives created for them and generously funded by government and corporations.

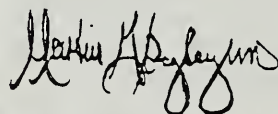
The average man's experience with medicine is very different from that of a woman. The only health maintenance experience he may have had is a sport's physical in high school, if he played interscholastic sports and most men don't get that opportunity. Though it is more common for today's fathers to accompany their children to physicians' appointments, most men still don't develop relationships with physicians.

Getting men involved with health programs meets another barrier. By nature they have a sense of invulnerability and they won't consider themselves being ill, getting old or ever needing medical attention. This sense was probably a necessary adaptation in our prehistoric forefathers who, in order to feed their mates and offspring, had to face mortal danger hunting the mastodon and mammoth armed with only spear and club. That, even today, this dangerous self-misperception is present in every man to some extent underscores its historical value—those in the primitive past who couldn't be headlong didn't survive and have no present day descendants. There is another facet of this instinct; some men gain a sense of self-esteem bragging about previously suffered injuries as if they are proof of bravery displayed—what could be called "the Red Badge of Courage syndrome." So it is not uncommon to hear guys subtly, or not so subtly, comment on old football injuries. I once knew a guy who thought it was cool that his teeth were gapped and tipped like a row of headstones in an old cemetery, the result of too many encounters with hockey pucks. Unfortunately, these tendencies have persisted but, in our modern time and highly developed world, they are unnecessary and dangerous instincts. Yet they continue to delay men in seeking medical attention.

Another reason men don't care for themselves is sheer laziness. However, that fault is shared by both sexes as can be seen in the fact that only about fifty-six percent of women who should get routine screening mammography do so regardless of all the low cost and convenient opportunities available and all the publicity about the incidence of breast cancer.

Although these obstacles exist, men have significant resources that can be used to bring them health programs like those women enjoy. First, they respond to public education campaigns. Over the past three decades, they have embraced dietary changes that have produced a significant decrease in the incidence of myocardial infarction among them. They also eagerly join cardiovascular boosting exercise programs if encouraged to do so. Additionally, more are beginning to obtain PSA and cholesterol levels, heme-occult determinations, stress testing, and other screening studies.

What is needed now is a vigorous public education campaign promoting men's health. Physicians, hospitals and other health agencies should dedicate their efforts to this as they did to advance women's care. The government should also assume the same major role in fostering men's health as it did so successfully for women. In fact, government funding probably will be more essential in promoting men's health as corporate funding may be harder to find. More than seventy cents of every dollar spent in our economy is directed by women, and corporations, particularly those producing cosmetics, home products, etc., were eager to fund programs for women hoping to curry favor with them. Men don't have such buyer leverage. Furthermore, some of the companies whose marketing targets them won't be suitable sponsors for health initiatives; I don't see the beer brewers' talking frogs being apt spokesmen in this crusade. Finally, men's health awareness may be best promoted in women's centers! There we find those who have traditionally been the guardians of family health. There we can invite women to make the effort to encourage their husbands, brothers, fathers, sons, friends, and other men in their lives to care for themselves. That is the stuff of which love is made.



Martin G. Begley, M.D.
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Absence of Metabolic Acidosis in Toxic Methanol Ingestion: A Case Report and Review

Matthew Sullivan, M.D. — Chih-Lung Chen, M.D. — John F. Madden, M.D.

INTRODUCTION

Methanol, or wood alcohol, is a solvent used in many commercial products such as paint removers and windshield washer fluid. Its ingestion may present as an elevated anion gap metabolic acidosis, blindness, and death. We describe a patient who presented several hours after drinking both ethanol and a solution containing methanol. He was asymptomatic at the time of emergency department presentation and although a serum osmolality indicated the presence of an osmolal gap, the electrolytes did not reflect the anion gap which is the diagnostic hallmark of methanol toxicity. Based on the history and the osmolal gap, the patient was started on ethanol and received hemodialysis. Although a serum methanol of 182.8 mg/dl was

eventually confirmed, the patient did not develop any sequelae following three days of therapy. This case supports the aggressive treatment of patients with presumed methanol ingestion. The reliability of the osmolal and anion gaps as screening tests are discussed as well.

CASE HISTORY

A 26-year-old male with a history of bipolar disorder presented to the hospital after being found asleep in his car on the side of the road. He stated that he had drunk half a bottle of windshield wiper fluid and a similar quantity of Windex brand glass cleaner. He further admitted to consuming "a few drinks" and estimated that this all transpired ten hours prior to arrival in the emergency department. The police who had discovered the patient and brought him to our department were unable to produce any containers of the substances consumed.

The authors are members of the Department of Emergency Medicine at Christiana Care Health Services in Newark, Delaware.

The patient complained of nausea but denied symptoms of vomiting, abdominal pain, or visual changes. He denied other ingestion or active suicidal ideation while stating that his intentions the previous evening had in fact been suicidal. On examination, the patient was oriented and answered questions appropriately. He did appear mildly intoxicated. His vital signs were pulse rate, 114 beats/minute, respiratory rate, 20 per minute, BP 146/78 mmHg, and temperature, 37.1°C. His pupils were four-mm and reactive. Fundoscopy revealed normal disc margins without edema or hyperemia. His skin was warm and dry. He had active bowel sounds and the remainder of his exam was normal.

The patient was started on a five percent ethanol in five percent dextrose infusion at 200 cc/hr, or approximately eight gm/hr, while awaiting laboratory results. These were as follows: Na, 147 mm/L; K, 4.3 mm/L; Cl, 109 mm/L; CO₂, 27 mm/L; Glucose, 77 mg/dL; BUN, 12 mg/dL; and creatinine, 1.0 mg/dL. His anion gap was 11 mm/L. A room air arterial blood gas showed pH, 7.138; pCO₂, 38.9 mmHg; and pO₂, 79 mmHg. The serum osmolality measured by freezing point depression was 371 mOsm/L. The calculated osmolality was 314 mOsm/L based on the ethanol level of 51 mg/dL, yielding an osmolal gap of 57 mOsm/L. Serum for methanol, ethylene glycol, and isopropyl alcohol were sent to an outside facility and would become available several hours into the patient's hospital course. Urine toxicology was negative for common drugs of abuse and urinalysis was negative for ketones and calcium oxalate crystals.

Nephrology consultation was obtained and the patient was started on hemodialysis through a right femoral Sheldon catheter following admission and five hours from initial presentation. The ethanol infusion was increased to 350 cc/hr while on dialysis. He was treated with thiamine 100 mg IV and was given folinic acid 140 mg IV every four hours for six doses.

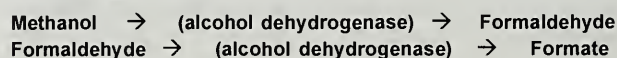
The initial methanol level, 182.8 mg/dL, was available 30 minutes after dialysis was instituted. Ethylene glycol was non-detectable and

the isopropanol level was five mg/dL. Ethanol therapy was discontinued on hospital day number three when the methanol level was 15.8 mg/dL. The patient remained asymptomatic throughout hospitalization and had serial electrolyte determinations, only one of which showed a gap greater than 12. That sample was drawn after dialysis and revealed an anion gap of 15. Similarly, bicarbonate levels were consistently above 20 mm/L. The patient was stable for transfer to the psychiatric floor following treatment.

DISCUSSION

This case illustrates the difficulties inherent in the treatment of the toxicological patient. As is often the case, our patient was a less than reliable historian given his psychiatric illness and intoxication. He admitted to drinking ethanol and window cleaner fluid, a source of methanol. However, he was largely asymptomatic ten hours after the ingestion, and initial laboratories failed to reveal an elevated anion gap or acidosis. The osmolal gap was elevated, but the most specific confirmatory test – levels of the toxic alcohols themselves – was performed at an outside laboratory and would not be available for several hours. Essentially, the decision to treat with intravenous alcohol and hemodialysis was based on the history and the osmolal gap.

Methanol toxicity is a toxicological emergency where treatment with intravenous ethanol along with hemodialysis is potentially lifesaving if initiated early. In fact, toxicity is not caused by the methanol itself but rather by formate, a metabolite whose generation accounts for elevation of the anion gap. Methanol is metabolized by alcohol dehydrogenase with formaldehyde as an intermediate:



Prior to formate induced toxicity, nonspecific symptoms such as nausea, vomiting, and lethargy are present. Outcome is optimized if the patient is treated before a significant anion gap acidosis is generated. The therapeutic use of the

more conventional alcohol, ethanol, hinges on its higher affinity for the alcohol dehydrogenase enzyme. It competes with the lower affinity methanol and prevents its metabolism to formate. As in the case discussed, alcohol is often fortuitously present in the patient's serum well before patient arrival in the emergency department, but this often presents a double-edged sword to the diagnosing clinician. While formate generation and clinical toxicity are delayed, the absence of anion gap acidosis on initial presentation may cause a potentially life or vision threatening ingestion to go unrecognized.

The validity of the anion and osmolal gaps in the diagnosis of methanol toxicity deserves special mention before a more detailed discussion of treatment is presented.

Anion Gap

That formate generation is directly correlated with anion gap acidosis and accounts for toxicity is widely accepted. Some studies have concluded that lactate may also play a role. The anion gap is based on the assumption that body fluids and serum are electroneutral, the total cation concentration equaling the total anion concentration. For the sake of convenience, only the larger and more variable contributors are included in the calculation:

$$\text{ANION GAP} = \text{Na} - (\text{Cl} + \text{HCO}_3)$$

Note that potassium, albumin, and various organic and inorganic ions are excluded from the calculation. A preponderance of negatively charged species absent from the equation results in an almost invariably positive result. The reference value has traditionally been 12 ± 4 mEq/L, although some recent studies have found the normal value to be 7 ± 4 mEq/L.¹ An increased anion gap indicates either an increase in the unmeasured anions or a decrease in the unmeasured cations.

Unfortunately, a high anion gap is neither specific nor entirely sensitive for methanol ingestion. Other conditions such as lactic acidosis and ketoacidosis and other toxins such as iron, salicylates, and ethylene glycol need to be con-

sidered in the patient with an elevated anion gap. Ethylene glycol is treated in a similar fashion to ethanol, but presumptive treatment involving an intensive care bed and hemodialysis is inappropriate based on this information alone.

A normal anion gap does not exclude the diagnosis of methanol ingestion. In the early stages of intoxication, the formate level is too low to produce a significant acidosis. Metabolism of formate by a folate mediated pathway and secondary routes of elimination such as renal excretion and pulmonary exhalation aid in the clearance of these initial low levels. The latent period may be as long as 12 to 24 hours post ingestion and is significantly prolonged through concomitant ethanol ingestion as previously discussed. In one study involving patients treated with intravenous ethanol, the median half-life of methanol was increased to 43.1 hours.² There have been at least five reported cases of significant methanol ingestion presenting without an elevated anion gap.³ Each of these cases involves co-ingestion of ethanol. Therefore, in situations involving ethanol or in early presentations within the latent period, a normal anion gap will be misleading.

Osmolal Gap

The reliability of the osmolal gap has recently been under much scrutiny. Osmolality refers to the number of particles per kilogram of solution. This value may be measured or calculated, with the difference between these two values, or osmolal gap, representing osmotically active substances not accounted for in the calculation. Potentially, these would include methanol, ethylene glycol, and isopropyl alcohol. In the setting of possible methanol ingestion, this test has the theoretical advantage of detecting methanol itself rather than its metabolite and thus providing evidence of toxicity during the latent stage when the anion gap would still be within normal limits. The equation is as follows:

$$\text{OSMOLAL GAP} = \text{measured osmolality} - \text{calculated osmolality}$$

Unfortunately, both terms of the calculation are of questionable reliability, casting doubt on its result. The existence of over 15 formulas to

determine a calculated osmolality reveals that there is little precision in this value. In fact, depending on the formula used, a given patient's osmolal gap may differ by up to 20 mOsm.⁴ A commonly used formula is as follows:

$$\text{OSMOLALITY} = 2(\text{Na}) + \text{glucose}/18 + \text{BUN}/2.8 + \text{EtOH}/4.6$$

The introduction of four independent measurements each with their own inherent laboratory error adds a further element of imprecision. In one study, the day-to-day coefficient of variance for a given laboratory was 9.1 mOsm, which is nearly the normal osmolal gap variability.⁵

The measured osmolality is also potentially unreliable. Only 80 percent of laboratories use the preferred method, freezing point depression osmometry. The alternative of vapor pressure determination is notoriously unreliable as volatile substances such as methanol, ethanol, and isopropanol will evaporate resulting in a value that is spuriously low.

Given the unreliability of both the measured and calculated values, it comes as no surprise that the difference, the osmolal gap, has failed to withstand close scrutiny. A normal value of less than ten has generally been accepted. However, one study examining 184 consecutive emergency department patients has found the normal range to vary between -10 and +20 mOsm.⁶ A second study population yielded 30 percent with osmolar gaps in excess of ten mOsm.⁷

Equally problematic is the poor correlation of this value with actual toxicity. As previously discussed, the anion gap becomes evaluated only in the presence of formate and does not reflect the methanol itself. Conversely, the osmolar gap will disappear with the metabolism of methanol to its toxic by-product. While methanol is a neutral, osmotically active species, formate is charged and electrically balanced by sodium so it is already included in the formula calculations. As a result, a patient presenting late in the course of methanol intoxication may exhibit a small or nonexistent osmolal gap despite toxic formate levels.

An effective screening test needs to be highly sensitive for the diagnosis in question. Unfortunately, both the anion and the osmolal gaps fail this important requirement.

TREATMENT

Treatment of methanol toxicity is uniformly successful if instituted in a timely fashion. Ethanol and hemodialysis are the mainstays of treatment, while gastrointestinal decontamination, bicarbonate therapy, and folate administration also have recognized indications. The use of ethanol hinges on its increased affinity—20 times greater—for the alcohol dehydrogenase enzyme as compared to methanol. This accounts for the delay in metabolism of methanol to formate, which depends upon its rate-limiting step, the alcohol dehydrogenase mediated conversion of methanol to formaldehyde. Controversy remains as to the exact pathophysiology involved in methanol toxicity and the possible role of formaldehyde, an intermediate with a one to two minute half-life, or even lactic acid.⁸ However, formate levels have been directly correlated with ocular toxicity and clinical deterioration, and this explains the use of methanol in this setting.

Historically, ethanol has been administered in the same fashion that many methanol-intoxicated patients have already indulged in prior to hospitalization. However, oral administration is complicated by gastritis, unpredictable pharmacokinetics, and the risk of aspiration. Intravenous administration is the route of choice, and this is achieved with five percent or preferably ten percent solutions of ethanol. Based on the volume of distribution of 0.5 L/kg, a loading dose of 0.6-1 g/kg is recommended and should be given over 20-60 minutes. Then, a continuous infusion of 65-130 mg/kg/hr should be adequate to maintain a serum concentration of ethanol targeted at 100-150 mg/dl. Adjustments are necessary for alcoholic patients and hemodialysis as ethanol is dialyzable. Serum ethanol levels must be checked frequently, initially ev-

ery two to four hours, to make sure that the target values are achieved. If intravenous alcohol is not readily available, a 20-30 percent concentration of oral alcohol may be given.

While alcohol remains the mainstay of initial treatment, it is at best a temporizing measure. It delays the metabolism but cannot remove this substance or prevent its eventual metabolism to the toxic formate. Side effects include CNS depression, hypoglycemia, hyponatremia, and dehydration.

Hemodialysis is effective as definitive treatment because it clears both methanol and its metabolites. It decreases the half-life of methanol to about four hours and will prevent all sequelae of methanol intoxication if it is instituted during the latent period. Widely accepted indications for hemodialysis include severe acidosis, CNS depression, and visual or fundoscopic changes. Relative indications include methanol levels of 25-50 mg/dl and the consumption of more than 30-40 cc of methanol in adults. Dialysis should be continued until the methanol level of 0-25 mg/dl and the acidosis has cleared. Hemoperfusion is not effective and peritoneal dialysis is inferior to hemodialysis. Even so, peritoneal dialysis is a measure that should be instituted while transfer to a facility with hemodialysis is being arranged.

Treatment with folate along with its active form, folinic acid (leucovorin), is also recommended. These substances replete stores of tetrahydrofolate, the cofactor in the catabolism of formate to carbon dioxide and water. While no human trials have demonstrated the clinical benefit of formate in methanol toxicity, theoretical considerations are supported by animal data. Rats have been known to be virtually resistant to methanol because they metabolize formate two to three times faster than primates through a well-developed folate pathway. A monkey model has demonstrated increased formate metabolism based on folate administration.⁹ The recommended doses are 50-75 mg of folate along with one to two mg/kg folinic acid IV every four hours for 24 hours.

Gastrointestinal decontamination consists of gastric lavage if performed within the first one to two hours after ingestion. Ipecac is contraindicated because of the potential for CNS depression inherent in methanol, and charcoal is of little use because it does not absorb alcohols. Even so, charcoal is often used because of suspicion of concomitant ingestion. Forced diuresis has a limited role due to the minimal excretion of methanol in the urine. Bicarbonate has been recommended because the presence of acidosis has been associated with a worse prognosis; no specific recommendations for its administration are agreed upon.

A recent article has proposed an algorithm for treatment that emphasizes historical information rather than laboratory values.¹⁰ Symptomatic patients with a definite history of ingestion should be immediately started on an ethanol drip and hemodialysis prior to laboratory confirmation. Confronted with a possible history or an asymptomatic patient, the clinician should initiate ethanol therapy while awaiting confirmatory testing. According to the authors, the methanol level alone should impact patient management in this situation. This level is available only as a "send out" in most institutions and will delay patient disposition several hours, but in spite of these limitations, this is the only laboratory value of sufficient accuracy to guide clinical decision making. The anion and osmolar gaps, on the other hand, are poor screens and add very little clinically useful information. They may be considered on an individual basis in the severe overdose patient, the authors conclude, but their routine use in every overdose or altered mental status patient is not warranted.

CONCLUSION

Early diagnosis and aggressive treatment are essential in the management of methanol toxicity. The latent period of methanol poisoning is a variable time period when the signs and symptoms of toxicity are absent even in the setting of significant ingestion; ethanol increases the duration of this period by inhibiting the metabo-

lism of methanol. The osmolal gap and the anion gap have been used as screening tests for toxic alcohol poisoning. However, the poor sensitivity and specificity of these tests limit their usefulness in clinical decision making. Ethanol therapy should be initiated in any case of possible methanol ingestion and continued until the diagnosis has been definitively ruled in or out by specific serum assay. Finally, hemodialysis provides definitive treatment for any significant ingestion.

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Using Mailed Patient Reminders to Increase Influenza Immunization Rates Among Older Adults in a Primary Care Office

James M. Gill, M.D., M.P.H.

ABSTRACT

Purpose: To examine the impact of mailed patient reminders on the rate of influenza immunizations for older adults in a large family medicine office in Delaware.

Methods: In October 1996, all patients ages 65 years and older who were established patients of the Christiana Care Foulk Road Family Medicine Center were sent a mailing urging them to receive an influenza immunization. Medical records were abstracted for each patient to determine receipt of an influenza immunization in 1995, 1996 and 1997. The proportion of patients who received an influenza immunization in the year prior to the reminder (1995) was compared to the proportion who received an immunization

the year the reminder was sent (1996). A secondary analysis examined influenza immunization rates in the subsequent year (1997), when no reminder was sent.

Results: Of the 289 patients in the main study population, 41.8 percent received an influenza immunization in 1995, while 55.4 percent received an immunization in 1996 ($p < 0.0001$). Immunization rates in 1997 did not change significantly from 1996, and continued to be significantly higher than in 1995. Rates were somewhat lower for persons ages 85 years and older compared to younger groups.

Conclusions: This study indicates that a mailed patient reminder had a positive impact on influenza immunizations for older adults in a large family practice office. This is a relatively simple strategy that, if widely used, could have a major impact on the health of older adults in Delaware.

James M. Gill, M.D., M.P.H., is Director of Health Services Research at Christiana Care Health Services in Wilmington, Delaware.

Since immunization rates remained less than optimal even with the patient reminder, it is likely that achieving optimal rates would require combining patient reminders with other strategies such as computerized reminders for physicians.

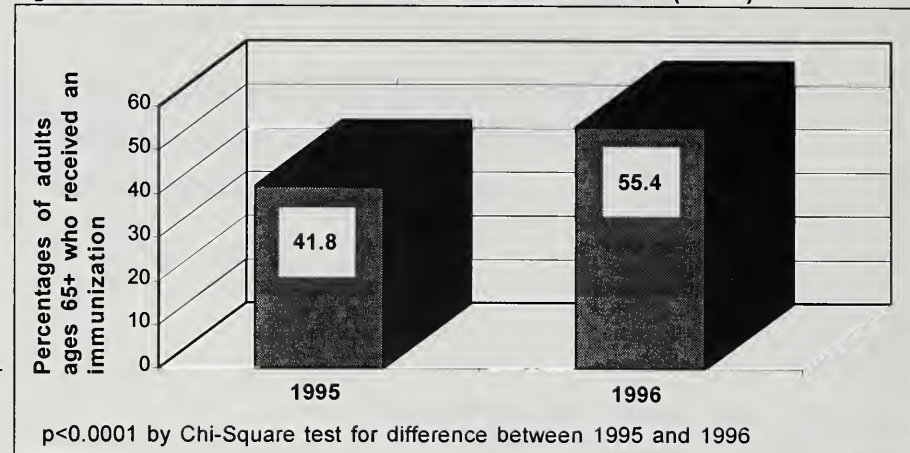
INTRODUCTION

Influenza is a significant cause of morbidity and mortality, especially for older adults and persons with chronic illnesses.¹⁻³ Annually, influenza causes about 20,000 deaths, 90 percent of them among persons ages 65 years and older.⁴ Immunizations are highly effective in preventing influenza and its complications.³ Because of the burden of illness associated with influenza in older adults, and the availability of a highly effective vaccine, it is recommended that all persons ages 65 years and older receive an annual influenza immunization.^{5,6} Despite these recommendations, many Americans in this age group do not receive influenza immunizations annually.^{3,4} A recent study by Delaware's Medicare Peer Review Organization found that 34 percent of Delawareans ages 65 years and older reported not having received a flu shot during the 1996-97 influenza season.⁷ This percentage is similar to what has been found among elderly in the general United States population.⁴

There are several possible ways to improve the rate at which older adults receive influenza immunizations. Since most patients receive immunizations from their physicians, one approach is to generate reminders to physicians to immunize their elderly patients during the autumn months. Several studies have found that reminders to physicians⁸⁻¹¹ increase the rate of influenza immunizations.

Another approach is to target the patient rather than the physician. Since office-based reminders usually capture patients only during office

Figure 1. Influenza immunization rates in 1995 and 1996 (n=285)



visits, they would not be effective for patients who do not visit their physician during the months in which influenza immunizations are given. Therefore, one might increase influenza immunizations by sending reminders to elderly patients to get an influenza immunization at the appropriate time. While mailed patient reminders have been frequently used by physician offices as a tool to improve preventive care,^{2,12,13} no previous studies have examined their impact on influenza immunizations for older adults in Delaware. This study examined the impact of mailed patient-reminders on the rate of influenza immunizations for patients ages 65 years and older in a large family medicine office in Delaware.

METHODS

Design and Setting: This was a retrospective cohort study. The study took place at the Family Medicine Center (FMC) of the Christiana Care Health Services (formerly the Medical Center of Delaware). The FMC is a large group practice and teaching site in Wilmington, Delaware. In the FMC there are six faculty and 25 resident physicians, all of whom see patients on a part-time basis.

Performance Improvement Intervention: In October 1996, a letter was sent to all FMC patients who were 65 years of age or older, or who had a chronic medical problem (e.g. diabetes mellitus,

210TH ANNUAL MEETING MEDICAL SOCIETY OF DELAWARE

NOVEMBER 19-20, 1999

SCIENTIFIC SESSION

Saturday, November 20, 1999
Hotel du Pont, Wilmington, Delaware

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This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education (ACCME) by the Medical Society of Delaware. The Medical Society of Delaware is accredited by the ACCME to provide CME activities for physicians, and takes responsibility for the content, quality and scientific integrity of this CME activity.

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210TH ANNUAL SCIENTIFIC SESSION

SATURDAY, NOVEMBER 20, 1999
HOTEL DU PONT, WILMINGTON, DELAWARE

MEDICAL SOCIETY OF DELAWARE ALLIANCE SPOUSES' PROGRAM

Greenville Suite

8:30 a.m.	Coffee and Conversation
9:00 a.m.	Brief Business Meeting ... <i>Update on Finances, Activities, County Reports</i>
9:15 a.m.	County Meeting ... Building on a Good Foundation: The Impact of the MSD Alliance <i>"...a small pebble makes a large ripple..."</i>
9:45 a.m.	Guest Speaker - Martin G. Begley, M.D. "Prognosis for the Future"
10:00 a.m.	Discussion
10:30 a.m.	Sweets for the Holidays - Chef Tom Hannum, Executive Chef, Hotel du Pont

SCIENTIFIC SESSION

6:15 a.m. - HEALTH SCREENING — Upper Foyer

CBC, Comprehensive Metabolic Panel, Lipid Profile, PSA

Compliments of Laboratory Corporation of America. Fasting recommended.

6:30 a.m. - REGISTRATION BEGINS — Upper Foyer

7:00 a.m. - MEDICINE AND RELIGION COMMITTEE BREAKFAST — Christina Room

Speaker: David Silks, M.D.

7:30 a.m. - EXHIBITS — Foyer and Gold Ballroom

8:00 a.m. - 9:30 a.m.

CONCURRENT WORKSHOPS — Second Floor Meeting Rooms

(PRE-REGISTRATION IS REQUIRED)

☒ A TUTORIAL ON READING CHEST RADIOGRAPHS — DuBarry Room

James Lally, M.D., Staff Radiologist at Christiana Care Health System (CCHS), Newark, Delaware

This workshop provides a review of the basic skills needed to interpret chest radiographs, focusing on the presentation of unknown clinical cases.

☒ BASIC LIFE SUPPORT TRAINING: CPR & SAED RECERTIFICATION — Georgetown/Sussex Rooms

Ross Megargel, D.O., State E.M.S. Medical Director, Delaware

This workshop will provide participants with a brief orientation to Delaware's Emergency Medical Service protocol. Participants will also be offered Cardiopulmonary Resuscitation and Semi-Automatic External Defibrillator recertification as authorized by the American Heart Association.

☒ SUTURING — The Grille

Jonathan Saunders, M.D., Plastic Surgeon - Private Practice, Newark & Wilmington, Delaware

This workshop provides instruction on the closure of simple lacerations and excisions of lesions in the office setting. Circumstances for referring a patient to a specialist are also discussed.

☒ ORTHOPAEDIC INJURIES: CASTING AND SPLINTING — Kent/New Castle Room

Leo Raisis, M.D., Chief - Section of Orthopaedic Surgery, CCHS, Newark, Delaware

Michael Axe, M.D., Co-Director - All Sports Clinic of Delaware, Partner - Private Practice

This workshop focuses on the application and removal of casting and splinting as well as the necessary precautions for each method. Indications and application of prefabricated splints will also be discussed.

LECTURES — DuBarry Room

10:00 a.m. — LEWIS B. FLINN LECTURE

AIDS UPDATE/HIV INFECTION

Calvin Cohen, M.D., Clinical Instructor — Harvard Medical School, Cambridge, Massachusetts

Dr. Cohen will review the current antiviral options for HIV as well as strategies for treating patients. He will also discuss approaches for resistant HIV treatment.

11:00 a.m.

UPDATE ON IMMUNIZATIONS

Margaret C. Fisher, M.D., Professor of Pediatrics — St. Christopher's Hospital for Children, Philadelphia, Pennsylvania

Dr. Fisher will discuss the indications for oral polio vaccine usage. She will also comment on advising patients regarding thimerosal and the consideration of adult vaccinations.

12:00 noon - LUNCHEON, AWARDS PRESENTATION & LECTURE — Gold Ballroom

12:30 p.m.

COMMUNICATION SKILLS: TECHNIQUES & STRATEGIES FOR CLINICAL PRESENTATIONS

Kelly Burke, Senior Consultant - Coram & Associates, Inc., Shrewsbury, New Jersey

Mr. Burke is also a former ABC Regional Reporter and Adjunct Professor at Northwestern University's Medill School of Journalism.

Mr. Burke will provide instruction on various communication skills including the instruments of a good presentation. By the end of this lecture, participants will be able to understand the impact of first impression, develop messages with high impact and retention, effectively use slides (focus on construction, content and interaction), effectively manage the Q&A period, and effectively communicate with the media and in public arenas.

1:30 p.m. - SCIENTIFIC SESSION ADJOURNMENT

DINNER DANCE — Gold Ballroom

"The Evolution of Medicine: Past, Present and Future"

6:30 p.m. - COCKTAILS (Includes open bar during the cocktail hour)

7:30 p.m. - DINNER AND DANCING (Music provided by the Jim Levendis Orchestra)

SCIENTIFIC SESSION REGISTRATION

SATURDAY, NOVEMBER 20, 1999 — HOTEL DU PONT

Please indicate number planning to attend:

_____ Medicine & Religion Committee Breakfast (Prayer Breakfast) — \$12 per person

_____ Spouses' Program — No charge

_____ Scientific Session — No charge for members; \$100 for nonmembers.

_____ Lunch — \$16 per person

(Please note that if you plan to attend one of the four concurrent workshops, you must pre-register below)

_____ Dinner Dance — \$60 per person (includes open bar during cocktail hour)

☐ Check here for vegetarian dinner option. How many? _____

TOTAL AMOUNT ENCLOSED: \$ _____

Concurrent Workshop Pre-Registration (Please select one)

- ☐ A Tutorial on Reading Chest Radiographs
- ☐ Basic Life Support Training: CPR and SAED Recertification
- ☐ Suturing
- ☐ Orthopaedic Injuries: Casting and Splinting

Name _____ Telephone Number _____

Please return this registration form, with your check, using the envelope provided. For table reservations/seating preferences for the Dinner Dance, call Mary LaJudice at the Medical Society of Delaware at 302-658-7596 or 1-800-348-6800. For information on overnight accommodations at the Hotel du Pont, call 302-594-3125.

GRANTORS

The Medical Society of Delaware gratefully acknowledges the assistance of the following with the 210th Annual Meeting:

Astra Zeneca Pharmaceuticals (*Miscellaneous event expenses*)
Bayer Pharmaceutical (*Speaker: Calvin Cohen, M.D.*)
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Kent County Medical Society (*Miscellaneous event expenses*)
Laboratory Corporation of America (*Screening services*)
New Castle County Medical Society (*House of Delegates' breakfast and incidentals*)
Pfizer-Roerig Division (*Speaker: Margaret C. Fisher, M.D.*)
Princeton Insurance Company (*Promotional material printing-in part*)
Rehabilitation Consultants, Inc. (*Coffee and danish - Saturday morning*)
Rhône-Poulenc Rorer (*Speaker: Kelly Burke*)
Sussex County Medical Society (*Flowers for Saturday's dinner dance*)

IN TRIBUTE

At the House of Delegates' luncheon, the Medical Society of Delaware will pay tribute to the following members who graduated from medical school fifty years ago:

Joseph E. DeLaurentis, M.D.
L. Mario Garcia, Sr., M.D.
Albert Gelb, M.D.
Harry L. Hoch, M.D.
Alois E. Maresch, M.D.
Domenic Panariello, M.D.
Jeung C. Sohn, M.D.
George R. Spong, M.D.
William L. Sprout, M.D.
George E. Voegelé, M.D.

The following is a list of Exhibitors for the meeting of the House of Delegates on Friday, November 19 (F) and the Scientific Session on Saturday, November 20 (S).

Abbott Laboratories (F,S)	Cover + Rossiter, PA (F,S)	Novartis Pharmaceuticals (S)
Aetna U.S. HealthCare (S)	Delaware Academy of Medicine, Inc. (F,S)	Organon Inc. (F)
Aircast, Inc. (S)	Delaware Curative Workshop (S)	Ortho-McNeil Pharmaceuticals (S)
Alfred I. duPont Hospital for Children (F)	Delaware Hospice (F)	Papastavros' Associates Medical Imaging LLC (S)
American Express Financial Advisors (F,S)	Diagnostic Imaging Associates, PA (S)	Pfizer (S)
AmeriHealth (S)	Disability Determination Service (S)	PHICO Group (S)
Astra Zeneca Pharmaceuticals (F,S)	duPont Pharmaceuticals (S)	PNC Bank (F,S)
Australian Physiotherapy Centers of Delaware (S)	First Union (S)	Principal Health Care of Delaware (F,S)
Autism Society/Parent Information Center of Delaware (F)	Glaxo Wellcome Inc. (S)	PRO Physical Therapy (S)
Balakhani, Mehdi, M.D. (S)	Home Health Corporation of America (S)	Pyramid Educational Consultants, Inc. (F)
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CCHS Breast Center (S)	MBNA (F)	TrailBlazer Health Enterprises, LLC (S)
CCHS Wound Care Center (S)	McBride Shopa & Company, PA (S)	Vanguard Capital/IFG Russell Advisors (S)
Christiana Care Infusion Services (F,S)	Merck & Co., Inc. - Urology (F,S)	Wilmington Trust (S)
Connectiv Communications (F,S)	MSDIS/Zutz/PLI Health Select (F,S)	Women's Imaging Center of Delaware (S)

heart disease, asthma, COPD). The letter explained the need to receive the influenza vaccine and urged them to make an appointment to receive their vaccine in the office in October or November. This study compared the rate of influenza immunizations for elderly patients of the FMC before and after the patient reminders.

Population: The study population included all persons ages 65 years or older as of September 1, 1995, who had visited the FMC prior to September 1, 1995, and after December 31, 1996. The first and last visit cut-offs were used to ensure that subjects were FMC patients from the beginning of the 1995 influenza immunization season through the end of the 1996 influenza immunization season. In order to examine whether or not the effects of the intervention were sustained into the subsequent year, a secondary population was identified. This secondary population met the above criteria and had also made a visit to the FMC after December 31, 1997. Nursing home patients were excluded.

Data Collection: A trained chart abstractor reviewed the office medical record for each study patient. The patient's date of birth, first and last visit dates to the FMC and dates of influenza vaccinations in 1995, 1996 and 1997 were abstracted.

Data Analysis: The primary analysis examined whether or not the likelihood of influenza immunization increased between 1995 and 1996. In a secondary analysis, influenza immunization rates were compared between 1996 and 1997 as well as between 1995 and 1997. Finally, it was determined whether or not the rate of influenza immunizations differed by patient age. For each analysis a chi-square test was used with $p < 0.05$ as the cutoff for statistical significance.

RESULTS

The main study population included 289 persons. Fifty-eight percent of the population was between the ages of 65 and 74 years; 33.7 percent was between 75 and 84; and 8.1 percent was 85 years of age or older. Of these persons, 229 (approximately 80 percent) were still FMC patients after December 31, 1997, and had a similar age distribution.

Figure 1 shows rates of influenza immunizations before and after the mailed reminder for the main study population. In 1995, 41.8 percent of the population had an influenza immunization. In 1996 that percentage increased significantly to 55.4 percent ($P < 0.0001$).

Figure 2 demonstrates how these improvements were sustained for the following year (when no reminder was sent to patients). For those who remained as office patients through 1997, the 1997 immunization rate was not significantly different from the 1996 rate, and continued to be significantly higher than the 1995 rate ($p < 0.01$).

The table on the following page shows the association between patient age and the likelihood of receiving influenza immunizations. The oldest

Figure 2. Vaccination rates in 1995, 1996, 1997 (n=229)

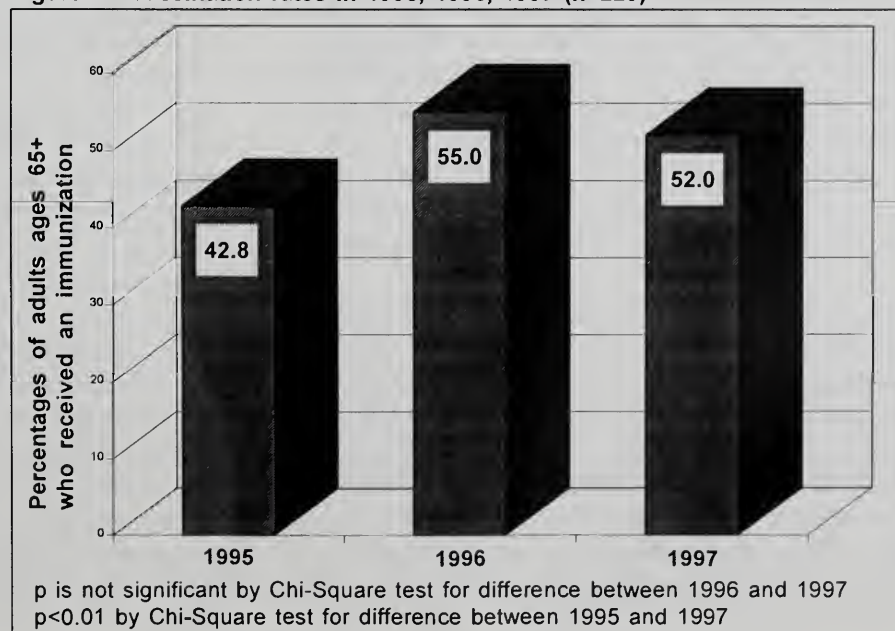


Table 1. Receipt of influenza immunization by patient age (n=285)

	Patient Age (Years)		
	65-74	75-84	85+
Year	# (%) Receiving Immunization		
1995	68 (41)	45 (47)	6 (20)
1996	91 (55)	57 (59)	10 (44)
1997*	73 (53)	41 (41)	5 (31)
* Only includes patients who were eligible for all three study years (n=229)			
**for all years $p < 0.1$ by Chi-Square test for difference between age groups			

patients (85 years and older) were the least likely to receive immunizations for all study years. However, because of the small number of patients in this age group, this analysis did not have enough power to show statistical significance. Of note: immunization rates for this oldest group increased similarly to that of younger groups.

DISCUSSION

This study indicates that a mailed patient reminder in a large Delaware family practice office had a positive impact on influenza immunizations for older adults. The percentage of patients ages 65 years and older who received the immunization increased from 41.8 percent before the reminder to 55.4 percent after the reminder. This represents a relative increase of 33 percent. These findings corroborate previous studies that have shown mailed reminders to have a positive impact on the rate of influenza immunizations in outpatient practices.^{2,14}

It is notable that immunization rates stayed relatively constant in 1997, one year after the mailed reminder was sent. This is despite the fact that no follow-up reminders were sent that year. It could be that many patients fail to receive immunizations because of lack of knowledge about the benefits of influenza immunization. Once their physicians educate them, patients may be more likely to continue to receive

annual immunizations. Conversely, it could be that the rate of immunization would continue to fall over a period of years. Further studies are needed to track immunization rates over a longer time period.

While the rates of immunization increased significantly after the mailed reminder, one could argue that the rates were still suboptimal. In fact, the rate of 55 percent is still lower than the goals stated by the U.S. Public Health Service in *Healthy People 2000*.¹⁵ Also, this rate is lower than that found in a survey study done by the West Virginia Medical Institute, in which 66 percent of Delawareans ages 65 years and older stated that they had a flu shot in the previous year.⁷ There are several possible reasons for this discrepancy. First, it could be that the rate found in our study is actually an underestimate. Since we captured data from office medical records, it is likely that some patients were immunized elsewhere. While this information is sometimes obtained from patients and recorded in their charts, this is not always the case. It could also be that the immunization rate obtained by patient surveys (as in the WVMi study) overestimates the true rate; patients who reported receiving a flu shot in the previous 12 months may have actually received it prior to that or may have received a different immunization.

Even if the rates found in this study are somewhat underestimated, it is likely that there is still significant room for improvement. This is particularly true for the oldest patients, who were the least likely to receive immunizations, and who are also at highest risk for complications and death from influenza. While mailed reminders may be a useful tool to improve immunization rates in physician offices, they are probably not sufficient to reach optimal rates. Previous studies have found that physician reminders, and in particular automated computerized reminders to physicians, can also increase the rate of influenza immunizations for older adults.^{8,10,11} It could be that targeting both physicians and patients would have a greater impact than either approach alone.¹² In fact, the Family Medicine Center has recently imple-

mented such a combination intervention, and a study is underway to measure the impact on influenza immunization rates and other preventive care measures.

There are several potential limitations that must be considered when interpreting the results of this study. Most important, since there was no control group, it cannot be certain that increases in immunization rates were due to the mailed reminder. It could be that these increases would have occurred anyway, as a result of other factors such as increased public awareness. Another potential limitation is the incomplete capture of immunizations, as mentioned above. Finally, since this study targeted older adults in one family practice teaching setting in Delaware, the results cannot necessarily be generalized to other specialties, settings, or populations.

Despite these limitations, these results strengthen the evidence that a simple intervention can improve influenza immunization rates for older adults. Given the widespread use of computerized data on patient demographics, it would be relatively easy for most primary care practices to identify their older patients and send reminders and information on influenza immunizations. If such strategies are used by a large number of primary care offices, it has the potential for a large positive impact on an important health issue for older Delawareans.

ACKNOWLEDGEMENTS

The author would like to thank Kate Rodrigue for her help in data collection, Stephanie McClellan for her work in data analysis and literature review, and Cheryl Mongillo for her assistance in manuscript preparation.

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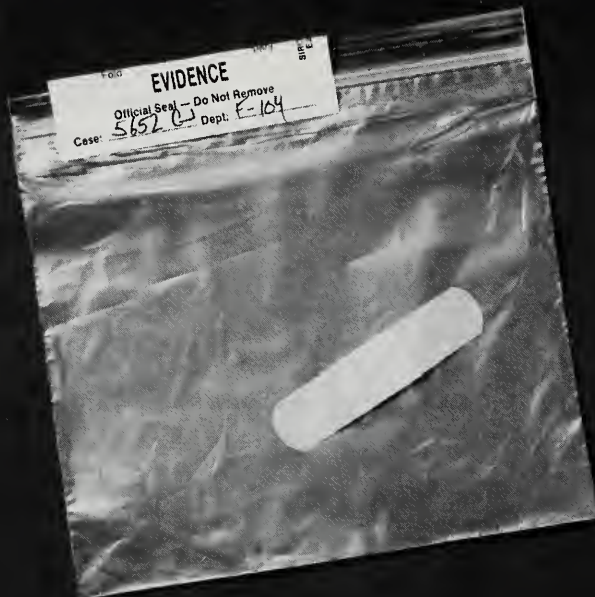


eXhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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The Complementary Side of Complementary and Alternative Medicine

G. Stephen DeCherney, M.D., M.P.H.

In the November 1998 issue of the *Delaware Medical Journal*, Editor Emeritus Dr. Wayne Martz, and Associate Editor Dr. Peter Rocca, voiced their opinions on alternative medicine. While it has not been our policy in the past to publish a polemic separated by months — or even separated by pages — we have become increasingly bold in both the choice of editorial commentary and the form that it takes. A few months ago, I spoke out against the proliferation of guns in America. In a more recent issue one of the most distinguished members of the Delaware Bar, Edmund N. Carpenter, II, wrote about the decriminalization of drugs. In this editorial, I would like to express an alternative view of alternative medicine.

First, I am obliged to note that I am no longer a disinterested party in complementary and alter-

native therapies. Approximately a year ago, Dr. Charles M. Smith, CEO and President of Christiana Care Health System, had the foresight to convene a committee to discern which among the many "New Age" therapies were worthy of introduction into the Christiana Care system. His instructions were quite explicit although our charge was broad. The Complementary Medicine Assessment Committee was to discern which among available therapies being employed in our community were indeed salutary and which were either unproven or dangerous. We had no limit to the types of therapy. For example, we have reviewed acupuncture, massage therapy, herbal therapy and others. For this past year we met twice monthly for two hours. The committee members consisted of physicians, nurses, clinical pharmacologists, exercise physiologists, psychological therapists and others on an ad hoc basis. The group is equally balanced among men and women. Additionally, the physician group is

G. Stephen DeCherney, M.D., M.P.H., is the Editor of the Delaware Medical Journal. He practices endocrinology in Wilmington and Newark, Delaware.

balanced between primary care practitioners and specialists. We often invite experts from specific disciplines such as Chinese herbalists or homeopaths. There are no restrictions on which therapies we will review.

In order to apply some rigor to the analyses, we first chose those therapies which are most commonly used in the community. These included many herbs such as ginseng, ginkgo, echinacea, St. John's Wort, and others commonly sold in pharmacies. We also reviewed massage (in all its forms), acupuncture, therapeutic touch, magnets, and chelation therapy. Nothing is too foreign or obscure to be eliminated out of hand. We have not yet reviewed iridology or reflexology or other of the less commonly practiced therapies.

As you know, my own background derives from many years working in both the laboratory on very esoteric bench biochemistry (carbohydrate side-chains of TSH at the NIH in Bethesda) to clinical pharmacology trials in humans. Over the years, I have been humbled by both our lack of knowledge, our incorrect assumptions and our consistent habit of making inferences on very little data. Nonetheless, there are well-worn practices of the scientific method and peer-review publications to hold our wilder speculations in check. Complementary medical therapies lend themselves poorly to such rigorous scrutiny. The reasons for this are not that they do not deserve it, but rather that few manufacturers can muster the capital to pass the FDA. Currently, approximately \$400,000,000 is invested in clinical trials to receive FDA approval. As most of these complementary therapies are "natural," they do not require this line of approval anymore than chicken soup for a common cold. That said, there are some solid lines of evidence, albeit from unlikely sources, which support the therapeutic efficacy of some complementary therapies. For example, the German Commission E, a government agency responsible for guaranteeing the safety of alternative therapies, publishes a compendium of them.

Why would a large health system such as Christiana Care need to embrace complemen-

tary therapies? First, approximately 60 percent of our patients are taking them with, or more likely without, the knowledge of their physicians. As the leading health provider in the community, we have been ill prepared to know what advice to offer to these patients. Second, as the dominant health provider in the community, we are obligated to understand the basic health status of our community. Third, we had the hunch that some of these therapies were valuable adjuncts to traditional practices. We had other more practical reasons for wanting to understand the therapies. As just one example of a problem with which we are still grappling, do these therapies have a withdrawal effect? Supposing that any one of these therapies is efficacious, and the patient has been taking an herb for years, what would happen if the patient needed general anesthesia? Should we stop the herbal supplement and risk an unknown withdrawal reaction? Some of these therapies have an anticoagulant effect, does this make surgery more risky? These are but a few of the questions we regularly debate in committee.

Consequently, our first task was to develop a screening matrix to separate those with potential biologic activity from those which did not. Our second, and arguably, more important, task was to discern which among them were actually harmful. Third, we have had to conjoin our collective wisdom about all those in between. Fourth, we had to explain to the advocates of these therapies that we are not discouraging their use, but simply trying to walk the fine line between the known and the unknown.

As with most interesting tasks, this one has proven to be quite difficult.

First, we developed a matrix that includes:

- Formulation - Are the herbal supplements processed or manufactured consistently from batch to batch?
- Does the herb come from a familiar source such as a local garden or is it imported from the shady side of the Mount Everest and can be gathered only by Urdu speaking natives?

- Do the claims of its efficacy derive mostly from anecdotes or have well-designed double-blind placebo-controlled studies shown evidence?
- How expensive is the remedy? Are patients being "ripped off"?
- What do we know about interactions with other medications such as anticoagulants or antibiotics or antidiabetic agents?
- Is there a recognizable withdrawal syndrome?
- What are the side effects intrinsic to the herb or therapy?

The committee operates by having one of our excellent librarians search the literature for information about the therapy. We do not stop at traditional citations, but rather review all that is reported. Much of the information is derived from claims in the lay press, advertising or the internet. Each member of the committee is assigned as a primary reviewer, with a secondary reviewer. He or she then presents a summary of what is known. The committee as a whole scores the therapy against the matrix. We then discuss the merits and drawbacks of the therapy. When everyone is satisfied that we have covered extant knowledge about the therapy, we place it into one of three categories. In the first category are those therapies that have proven efficacy, appear to be safe, and have practitioners in the community who are knowledgeable in their application. If the therapy passes these rigors, then it is recommended to the appropriate body at Christiana Care, such as the Pharmacy and Therapeutics Committee, for entry into the Formulary. In the second case, we feel that there is some anecdotal evidence for efficacy and little known risk. In this instance, we have recommended that the patient be allowed to continue the therapy in conjunction with conventional therapy with the knowledge and explicit approval of his/her treating physician. In the last case, the committee may find sufficient reports of harm or injury that the therapy is placed in the potentially dangerous group to be avoided by the community.

After reviewing approximately 30 or 40 of these therapies, the Complementary Medicine Assessment Committee has recommended the following therapies to be accepted at Christiana Care:

echinacea, saw palmetto, acupuncture, massage therapy and milkweed thistle. I am sure others will be added to the list as we review them.

Echinacea seems to reduce by half the symptoms of a common cold. There is little evidence that it prevents colds when taken continuously.

Saw palmetto reduces prostate volume and may help with benign prostatic hypertrophy.

Acupuncture is recommended in certain pain syndromes and for the hyperemesis of pregnancy.

Milkweed thistle has a narrow spectrum of action but seems to reduce acute hepatic inflammation.

Unfortunately, the mechanism of action for many of these therapies is unclear at best. Note, however, that in each case, they work systemically. Intrinsic to this notion is the fact that metabolism is somehow altered, which may mean there are subtle interactions with other conventional therapies. As these are unknown, it is difficult to know how to combine these together adjunctively. There are no rigorous studies to help us with drug-drug interactions.

We have not avoided controversial therapies such as chelation or therapeutic touch. We have concluded that there are no good data to support chelation therapy, that the theory is flawed, and that it may do more harm than good. We are recommending that your patients avoid chelation therapy unless it is for heavy metal intoxication, for which it is the treatment of choice.

Therapeutic touch has beguiled us. While there is a large body of literature in its support, there are no controlled trials (save the one in *JAMA* by a junior high school girl debunking it). Nevertheless, there is a large group of practitioners, mostly nurses, who are convinced that it improves the welfare of patients. We are neither convinced nor have we outrightly rejected it either.

The committee, composed of rather traditional practitioners, has been extraordinarily open-

mindful about each topic. They have learned to leave their prejudices outside the conference room. We will continue to review all the most recent additions to the growing list of claims for complementary therapies. We are often reminded that Aspirin, although a brand name from Bayer, is derived from willow bark and that digitalis originated from foxglove.

In summary, many of us believe there is a place for complementary therapies. As mentioned above, some have decidedly serious side effects and should be recognized and avoided. But as all seasoned practitioners should recognize, we need as many therapeutic approaches to diseases as we can find. Especially with chronic diseases we fail to cure often, we muddle through as best we can, and we should be interested in whatever therapies seem to offer our patients relief from daily misery. Quoting Freud, when asked what psychiatrists actually do, he said: "We take neurotic misery and turn it into ordinary human suffering." We should be mindful that many of these complementary therapies offer an adjunct to attenuating ordinary human suffering.

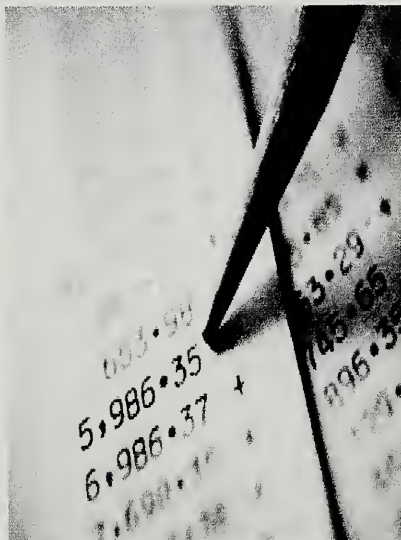
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A Moment of Silence Obituaries

The following obituaries are offered in memory of John J. Lazzeri, M.D.,
Carl Gray Pierce, Jr., M.D., and A. Henry Clagett, Jr., M.D.

JOHN J. LAZZERI, M.D.

Submitted by Norman P. Jones, M.D.

After a short illness, John J. Lazzeri, M.D., died in his home on June 4, 1999 at the age of 83.

John was born in Blanco, Pennsylvania, graduated from Penn State in 1941 and Temple Medical School in 1944. He served his internship at Wilmington General and at Lovell General Hospital, Fort Devers, Massachusetts. He also served overseas in 1946 and 1947 at the 98th General Hospital in Munich.

In 1948 he established a family practice in Smyrna from which he was recruited by the medical staff at Kent General Hospital in 1969 to become Director of Emergency Medi-



cine. John retired from this position in 1981. Dr. Lazzeri was preceded in death by his first wife Alfreda in 1975 and is survived by his current wife, Ellen Stant Lazzeri, formerly Chief Obstetrical Nurse at Kent General Hospital, as well as five sons, three stepchildren, six siblings, grandchildren and step-grandchildren.

John was the archtypical family doctor who furnished medical care in an early rural setting and always had interest and compassionate concern for his patients, his community, his colleagues, his family and all with whom he worked and associated as his career in medicine progressed.

CARL G. PIERCE, JR., M.D.

Submitted by James Beebe, Jr., M.D.

Carl G. Pierce, Jr., known to his friends and colleagues as "Bud," was born in Pitcairn, Pennsylvania April 18, 1920, and died July 26, 1999. After graduation from high school in Pitcairn, he obtained a B.A. degree from Maryville College, Maryville, Tennessee, where he met his wife of 55 years, Meredith Preston Pierce.

He attended midshipmen's school in Chicago after graduation from college and served in the Navy as a line officer aboard a destroyer in the North Atlantic from 1942-1944.

He then went to Jefferson Medical College, Philadelphia, Pennsylvania graduating in 1950.

He served an internship in City Hospital, Binghamton, New York.

I had met Bud when he visited relatives in Rehoboth and spent a summer working at Beebe Medical Center in 1949 as a student preceptor.

I had just started my practice in surgery, and since we desperately needed good young physicians in the area, I called and invited him to join our practice.

As his wife states, they had no idea they would become "true Sussex Countians and no other place could have made Bud feel more needed or at home." They stayed on until his retirement and finally his death. He was a member of the Beebe Clinic, which later became Seashore Medical, from 1950 until he retired July 1, 1987.

He was very active in the medical profession and also in the community. He served as Vice President, Beebe Clinic; President, Medical Staff of Beebe Medical Center; President, Sussex County Medical Society; President, Sussex Cancer Society; Member Board of Medical Practice for Delaware; Chairman, Medical Advisory Board of

Delmarva Easter Seal Rehabilitation Center in Georgetown, Delaware; and Fellow, American Academy of Family Practice.

He had a keen interest in Beebe School of Nursing where he served as the student nurse physician for many years and also taught some pediatric classes. Dr. Pierce had a long association with Beebe School of Nursing. He taught the student nurses microbiology and is remembered

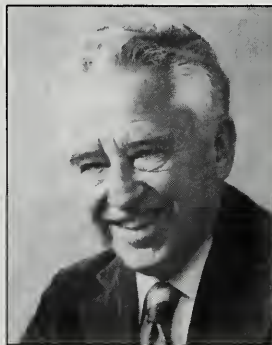
by those he taught as tough, but fair. For years he also served as the school physician giving yearly physicals and treating the students when they were ill. When Pediatrics was added to the curriculum being taught at Beebe School of Nursing in 1968, all the students spent two days in his office. In the environment of that office they learned growth, development, immunizations and how to treat diseases that affected children. Dr. Pierce was

always willing to share his knowledge and philosophy of child care with the students. I'm sure that every student that had the experience of being in his office heard him say, "Little mother, the common cold is not treated with antibiotics, treat it with hugs and kisses instead."

Many of the nurses at Beebe Medical Center in the over 50 age group remember Dr. Pierce fondly as their friend and mentor. His love for his family, children, delivering newborns and the elderly made him more than just a physician. He was a real person who truly cared.

He was a member and elder of the Westminster Presbyterian Church in Rehoboth; had been a member of the Kiwanis Club and an active member of the Rehoboth Volunteer Fire Department where he enjoyed riding in the rear seat of the ladder truck. His basement is filled with memorabilia of fire department equipment, model trucks, etc.

In his retirement he enjoyed doing needlepoint,



taking long trips on freighter-passenger ships to South America, New Zealand, Australia and Scotland.

He was an avid reader, enjoyed gardening and spending time on Rehoboth Bay in his pontoon boat.

He was well loved by his patients, friends and colleagues. We worked together for over 35 years and never had a serious argument. I for one will really miss him.

He is survived by his wife, Meredith, three daughters, Meredith Pierce Cox, Pamela Pierce Wilson, Margaret Pierce Collins and two sons, Carl G. Pierce, III, and W. David Pierce, a twin

sister, Betty Evans and ten grandchildren. The following is a eulogy by his daughter that sums up his life:

"Our family believes that their husband and father, Carl Gray Pierce, lived according to the standards and ethics set forth in the Hippocratic Oath: 'With purity and holiness will I pass my life and practice my art... Whatsoever house I enter, there will I go for the benefit of the sick... May it be granted to me to enjoy life and the practice of my art, respected always by all men...' We mourn his passing but celebrate a life well lived as a loving, nurturing husband, parent and physician."

A. HENRY CLAGETT, JR., M.D.

Submitted by Arthur W. Colbourn, M.D.

Henry Clagett was born on May 4, 1912 in Philadelphia. He was an only child raised in a three-generation household. There was a tradition of medicine in the Clagett family. Henry's father was a physician, initially a family practitioner and later a radiologist. Henry was educated in the public school system in Philadelphia. After three years of undergraduate education at the University of Pennsylvania, he entered Hahnemann Medical College and was graduated in 1936. He interned at the Homeopathic Hospital (later to become the Memorial Hospital) in Wilmington. His father encouraged him to enter general practice, and he did so for a year in Sussex County. Henry had many wonderful stories and memories from his year as a country doctor, but he felt unsuited to that lifestyle and returned to Philadelphia for additional study at the Graduate School of Medicine at the University of Pennsylvania.

Henry developed an interest in cardiology during his years of training in internal medicine,

and he pursued that interest as Resident in the Heart Station at the Rhode Island Hospital. Cardiology was in its infancy, and the Rhode Island Hospital was one of only three approved cardiology training programs in the United States. The evaluation of the heart murmur was foremost, and the stethoscope was the primary diagnostic tool. Electrocardiography was a relatively new laboratory test. The world's leading experts in cardiology could all fit into a small room, and Henry came to know most of them personally.



The war in Europe began during his year of cardiology training at the Rhode Island Hospital. Henry entered the army, and was stationed initially at the Walter Reed Hospital in Washington. He advanced through the ranks of the medical corps, and was soon on his way to England. At age 31, he became Chief of Medicine at the 90th General Hospital, serving in England and France. As was the case for so many of his generation, his World War II experience was the defining period in his life. His recollec-

tions and experiences during those years are eloquently recorded in his memoir, *Reminiscing: My Life in Medicine*.

Henry returned to Wilmington following the war to practice cardiology. For many years he and Dick Durham were the only cardiologists in Wilmington. He witnessed tremendous change and advancement in the field of cardiology during his lifetime, as well as maturation of the medical community in Wilmington. He served as Chief of Cardiology at the Memorial Hospital from 1946 to 1970 and Chief of Cardiology of the Wilmington Medical Center from 1970 to 1976. Despite his long-standing disdain for "hospital politics," he contributed significantly to the growth and reputation of the section of cardiology. For years he was truly the Dean of cardiology in Wilmington.

Henry received many honors during his medical career. He was Clinical Professor of Medicine at Jefferson (of which he was particularly proud, as Jefferson had been his father's *alma mater*), as well as Associate Professor of Cardiology at the University of Pennsylvania Graduate School of Medicine. He was a Fellow of the American College of Physicians, and served as its Governor, receiving the ACP Laureate Award in 1993. He was also a Fellow of the Royal Society of Medicine (London).

Henry retired in 1988 after 52 years in the practice of medicine. Henry had a natural gift for writing, and in fact had been editor of the *Delaware Medical Journal* from 1955 to 1965. In retirement he pursued this interest, mastering the computer and word processing in his eighth decade. He wrote two wonderful manuscripts: *Be Swift to Love*, a history of the Memorial Hospital, and *Reminiscing: My Life in Medicine*, his personal memoirs.

Henry was able to devote much time in retirement to his love of woodworking. He loved a fine piece of wood. He was particularly fond of several planks of walnut, which his best friend Bob Hazzard had saved from a fallen tree on his farm. He saved this wood for over ten years until he felt his skills were to the point that he was able to complete a wonderfully crafted Chippen-

dale chest. Henry also loved fine food, particularly seafood. In spite of his history of coronary bypass surgery, Henry never obsessed over his cholesterol intake. It was not at all unusual for him to drive hours to the Eastern Shore of Maryland for a seafood dinner. For years he relished an annual fishing trip to a cabin on a picturesque pond in Maine. The trip was as much for the local lobster as it was for the fishing.

Henry always dressed impeccably. He was a wonderful conversationalist, and underneath what seemed a very formal outward demeanor, was a wonderfully dry and often irreverent sense of humor. I received one of the first copies of his memoirs *Reminiscing* in 1996. He enclosed a note saying that I should "keep it away from the children," and that if I didn't want it around the house he would send his secretary by to pick it up. He went on to explain that after he decided to have the manuscript published, he felt compelled to "clean it up a bit." He found, however, that when all of the vulgarity was deleted it lost its character.

I was fortunate as a young physician returning to Wilmington in 1978 to join Henry in the practice of cardiology. He remained my mentor until his death more than twenty years later. Henry loved to teach, and he enjoyed nothing better than to call me into his exam room to listen to an unusual murmur. Henry had much to teach about the clinical practice of cardiology, but much more to teach about being a physician. There was never a question that Henry truly loved the profession of medicine and cardiology in particular. In spite of trends in the profession that Henry found distasteful, he never gave into cynicism. For Henry, the patient always came first, and his patients recognized his genuine concern and remained devoted to him. Ten years into Henry's retirement, those patients who I had inherited never failed to ask during their office visit "how Doctor Claggett was doing?"

Dr. Nicholas J. Fortuin, Professor of Medicine at The Johns Hopkins University School of Medicine, wrote of Henry in the introduction to *Reminiscing, My Life in Medicine*: "Henry's strong personality permeates his story. He is

sometimes gruff and judgmental, always kindly and concerned when patients or family are involved, direct and to the point, caustically intolerant of bad medical practice or puffery, sometimes impetuous but always the true gentleman physician. Underlying all of this is a remarkable and admirable sense of integrity and a clear understanding of his absolute devotion to the practice of medicine over a long and successful career."

Henry Clagett was one of the last of a generation of truly gentleman physicians to practice here

in Wilmington, and these individuals are largely responsible for our profession's excellent reputation in this community. All of us currently in practice are indebted to that legacy.

Henry died on August 3, 1999. His wife of 21 years, Margery Metz Clagett, three sons, Peter of Newark, Delaware; Hal of Wilmington, Delaware, and John of Orlando, Florida; a granddaughter Kathleen Olmes and great granddaughter Hannah Elizabeth of Milton, New Hampshire survive him.

The following is an excerpt from an obituary for A. Henry Clagett, Jr., M.D., submitted by Editor Emeritus E. Wayne Martz, M.D. We have provided only parts of this obituary due to repeats of information.

"With the death of Henry Clagett on August 3, 1999, Delaware lost one of its finest scholarly gentleman physicians of years past. Henry had been living at Stone Gates for a number of years, and more recently in their Assisted Living section, as his life became more and more circumscribed by increasing anasarca and multiple physical problems. Since May his rest had been troubled by increasing nocturnal dyspnea. However, as recently as July 13, Bob Lennon (Memorial Hospital Administrator) and I took him to lunch at his favorite restaurant in Chestertown.

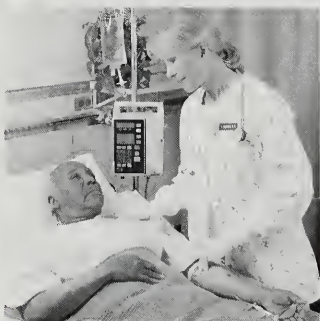
His mind was clear and he seemed to enjoy himself thoroughly, so things were not all bad. ... His unselfish devotion to his patients and his pride in his profession thrust him into many leadership roles in the Delaware medical community ... He thoroughly enjoyed teaching and took an active leadership role in teaching Residents and medical students. His quiet reserved manner sometimes hid the warm and caring person behind it, but all who got to know him were unanimous in their admiration for this truly remarkable man."

On The Cover

Charles Burchfield - The Mysterious Bird c. 1917

Throughout the various stages of his artistic career, Charles Burchfield captured not only the appearance of nature, but also his personal emotional response to the natural world. While many artists of this period responded to artistic developments abroad, Burchfield turned inward and expressed his emotions through his landscapes.

At the time Burchfield painted The Mysterious Bird, which is done in watercolor and pencil on paper, artists had been exploring the idea of "synesthesia." This is the notion that a given sound or word, for example, could correspond to a certain color. Burchfield said that in this work he was trying to find a visual equivalent to the sound of an unseen bird he had heard, as well as express the emotion it produced in him.



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**A New Mind Set For a New Era,
A Physician's Commentary on the Health Care Crisis and Society**

(Malcolm S. Watts, M.D. - Vantage Press, N.Y., 1995, 105 pages, \$12.95)

David Platt, M.D.

Malcolm Watts is a medical academician, an internist, and an award winning medical journalist. The theme of his book is that health care today must focus on the patient's well being, and the quality of his/her life and personal fulfillment. It must also take into account the quality of life of the nation and of the planet. That is surely a tall order, and at the beginning of reading the book I could not tell whether I would end up believing the author to be a purveyor of pap or a visionary.

Dr. Watts begins with a list of the deficiencies in present day health care: ever rising costs, overabundance of superspecialists and a shortage of generalists, increasing administrative burdens, malpractice litigation and defensive medicine, control of health care out of the hands of doctors, social inequities and the rise of special interest groups, illegal drugs and gun violence, overpopulation and the pollution of the planet, and failure to recognize global interdependency.

As examples of organizations which are working toward the right goals, the author cites International Physicians for the Prevention of Nuclear War and People to People, International. He insists that physicians must use their skills as

teachers to promote the health, well-being, quality of life, and personal fulfillment of their patients.

Dr. Watts sums up his book: "A new mind-set ... will accept the reality of global social, economic, political, and technological interaction and interdependence. It will focus upon improving health and well-being for humans everywhere. ... The new mind-set will promote health, well-being, quality of life, and personal fulfillment as a modern expression of a right to life, liberty, and the pursuit of happiness as personal, societal, and ultimately global goals. It will seek to achieve these goals within a growing ... understanding of the fundamentally biologic nature of humans, of human societal institutions, and of the human planetary environment. The new mind-set will view a legacy for the future of humankind as at least as important as its heritage from the past and its exploitation of the present."

My conclusion is that Dr. Watts has not written pap. He has framed well many of the problems of present day medicine. His suggestions, however, for correction of these problems are sketchy and inadequate. He needs now to write a sequel to this book which will suggest more of the answers.

David Platt, M.D., is a retired family practice physician and a member of the Medical Society of Delaware.



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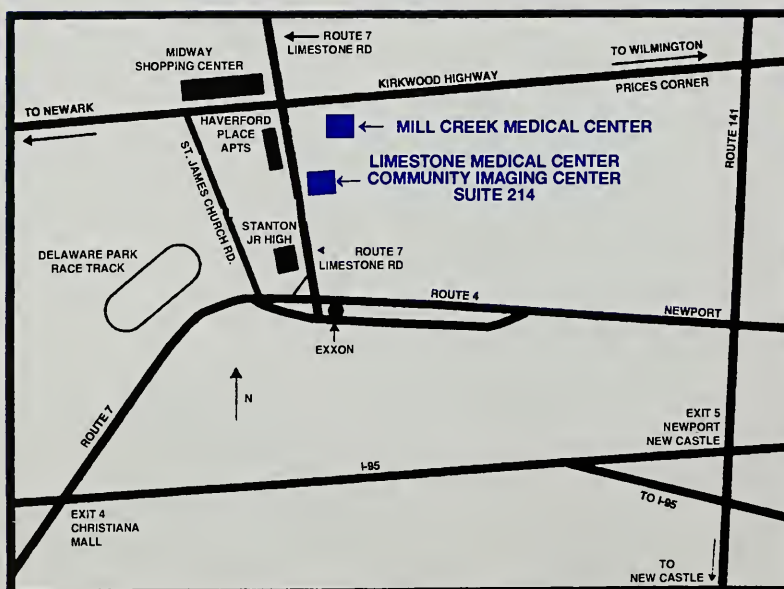
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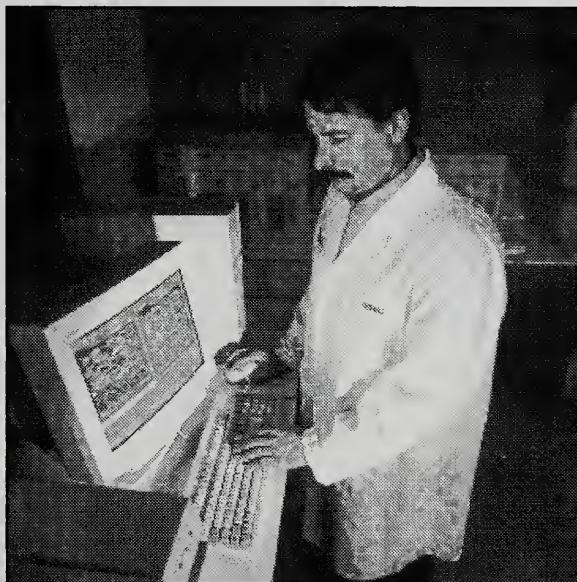
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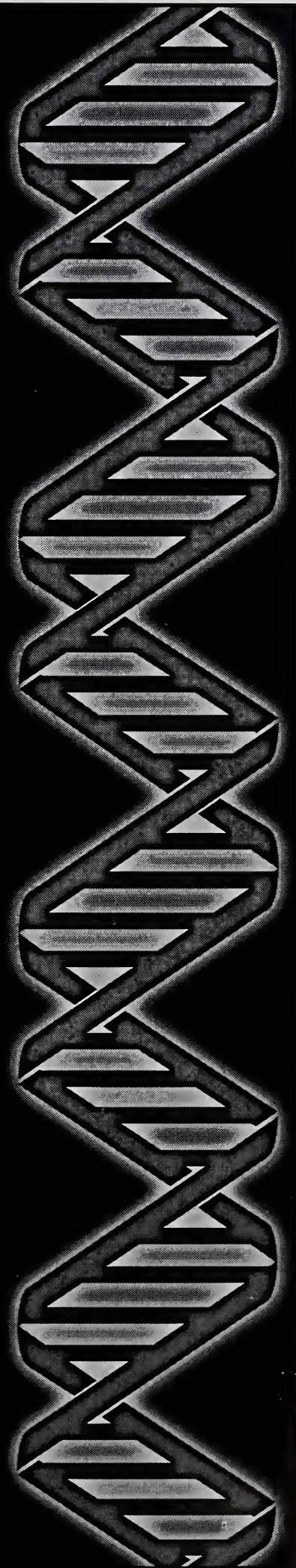
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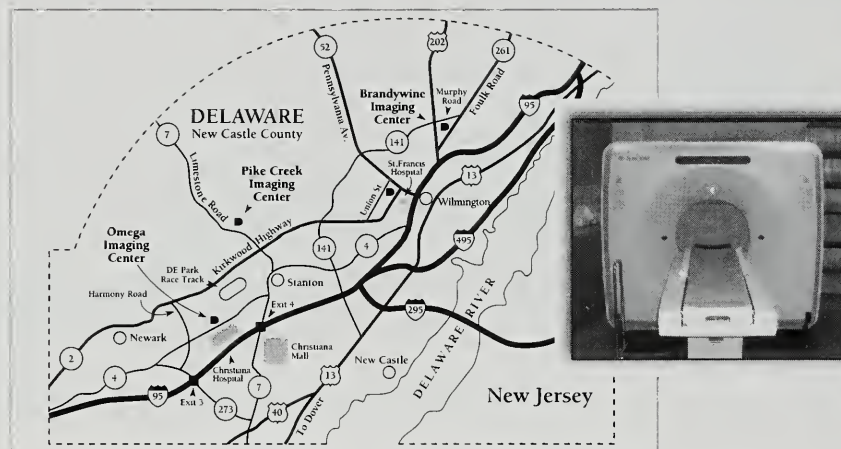
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On the Cover: Peony Table Lamp, ca. 1906-1910, created by Louis Comfort Tiffany and Tiffany Glass & Decorating Co. This and 44 other Tiffany works from The Neustadt Museum of Tiffany Art in New York City, will be on view at the Delaware Art Museum through March 5, 2000. For more information, please see page 473.

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A Progress Note, Upon Passing the Torch

Martin G. Begley, M.D.



It is hard to believe that a year has passed since I was entrusted with the honor of serving as your president during the 210th year of the Medical Society of Delaware. When time seems to be passing quickly, it is said that you must be having fun. I have had fun. Not the euphoric fun of the carnival, the exciting sports event or the family party. Rather it has been a deeper more satisfying fun of doing good work with good people.

As I reported to you last year, I had some goals to achieve during this past year. Those were the goals that you and your representatives in the society had chosen during a Strategic Planning Retreat I chaired in March of 1997. Holding that retreat was important to me because my aim as I approached the office of president was to serve

your interests as I deeply respect the members of this society and their values.

The goals that we chose during our planning retreat included:

- Develop strategies to better deal with the changing health care environment;
- Improve communications;
- Increase member involvement in political action;
- Modernize the physical plant and computer capacity of the Society;
- Find ways to reduce the burdensome hassles physician's face in their practice;
- Secure necessary revenue streams for the Society.

How have we done? Well, I am happy to report that we have done very well. As I have included in my President's report, and as the Report of the Ad Hoc Committee on Strategic Plan Oversight concurs, almost all of the goals have been met.

Martin G. Begley, M.D., is a diagnostic radiologist practicing in Dover, Delaware. He is the president of the Medical Society of Delaware.

I will not go into all the details of these successes as they are covered in the reports of the annual meeting that will be published in later editions of this Journal. However, I want to point out some important areas: Physician Organizations have been created, essentially statewide, and each has achieved at least one contract. Our communications capability is dramatically improved and we can get information to the membership extremely rapidly, respond to member concerns promptly, and organize grassroots activities quickly. Additionally, we have a new communications and government affairs director who has been elaborating our media contacts. This year DELPAC has more than 200 members, a 60 percent increase over last year. Also, more physicians are acting as legislative physicians and we are ever building better relationships with our elected representatives in Dover and Washington. The office areas of the Society have been enlarged; a much needed and deserved physical plant improvement. We have had increases in revenues from our subsidiaries, especially MSDIS. We have a new finance director and have completely revamped our financial reporting structure with creation of a holding company that will improve oversight, cash flows and enhance tax filings. Lastly, I can add that your society is in excellent financial condition.

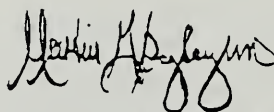
In addition to pursuing these strategic goals, your society has continued the ongoing work—continuing education, physician's health, ethics, public laws, etc.—and many other functions of the society that improve medical care for all Delawareans.

In short, this has been a very good year for your society. In saying so, I must rush to point out the excellent job done by our committees and other officers. Even more worthy of praise is our staff. They are first class professionals who demonstrate daily a deep devotion to our society. I want to recognize each of them individually: Mary LaJudice, Coreen Haggerty, Carl Kanefsky,

Kristine Riccardino, Jeff Rigor, Ginger Gerhart, Debbie Brooks, Cindy Wright, Alma Friedman, Anne Allen, Julie Bodenstab, and Karen Melnick. I especially want to recognize Mark Meister our Executive Director. He has done outstanding work, this year as he has in the past. He admirably manages and represents our society throughout our state and at every business, health care, government or community meeting I attended, someone commented on Mark's efficiency, courtesy, hard work and, especially, his integrity. We owe him deep appreciation and I happily presented him the 1999 MSD President's Award at our annual banquet to express our collective gratitude.

As I complete my term as your President, I have plans to remain involved with the society and look forward to new ways to serve the patients and physicians of Delaware. I especially look forward to working with our fine new President, Dr. Michael Alexander, and our other new officers.

In concluding, I am reminded of a comment made by Mikhail Gorbachev. When asked what he thought were the greatest achievements of mankind he promptly responded, "There are two: the growing of wheat and the creation of classical music." I would agree with him but would add another of mankind's great achievements: the formation of groups, alliances, fellowships, and other groups of people dedicated to and working for the common good. This society is one such institution. It has admirably served the people of the First State for 210 years and will do so into the future. Thank you for giving me this unique opportunity to serve the Medical Society of Delaware and its honorable members.



Martin G. Begley, M.D.
President

Pharyngitis in Children

Magdy W. Attia, M.D. — Theoklis Zaoutis, M.D.

INTRODUCTION

Acute pharyngitis is defined as an infection of the pharynx and the tonsils. Pharyngitis, tonsillitis and pharyngotonsillitis are interchangeable terms and are often used to describe the clinical diagnosis in patients with sore throats regardless of the etiology. The presence or absence of the tonsils has no bearing on the incidence or the course of the disease.¹

SCOPE

The exact incidence of pharyngitis is not known. However, pharyngitis is the third most common

diagnosis of all outpatient visits with an average of 24 visits per primary care practice per week.² Pharyngitis is the second most common diagnosis in the pediatric age group. In 1995, in children 1-15 years of age, there were over 10.3 million ambulatory visits that carried an ICD-9-CM code of sore throat/tonsillitis, of which approximately 1.9 million were labeled streptococcal sore throat. This respectively represents 6.4 percent and 1.2 percent of all ambulatory visits made by this age group in 1995.³

Similarly, the cost of caring for these children in the United States is undetermined. In Ontario, a Canadian province of 11 million people where only 8-20 percent of persons with sore throat actually visit their physician, the cost of care in 1994 was \$200 million. One can extrapolate that the cost in the US today is in the billions.^{4,5}

Both authors practice pediatrics at Alfred I. duPont Hospital for Children, Wilmington, Delaware and Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania.

ETIOLOGY

Pharyngitis is caused by numerous pathogens, most commonly viral. However, bacterial causes, in particular group A beta-hemolytic streptococci (GABHS), are of special interest and require proper diagnosis and treatment. Common causes and rare etiologies of acute pharyngitis are listed in Table 1.

VIRAL PHARYNGITIS

There are two different clinical presentations for viral pharyngitis that can be observed. The patient may present with a mild syndrome of low grade fever, significant coryza, cough, mild erythema and swelling of the tonsils with or without exudate. Generally, patients with these findings have no significant cervical adenopathy. A complaint of a sore throat may be absent and signs of pharyngitis are only a part of the picture of a common cold or croup. In this scenario one can suspect rhinoviruses, coronaviruses, respiratory syncytial virus or parainfluenza viruses as the causative agent.^{6,7,8}

On the other hand, a more severe syndrome with significant fever, sore throat, malaise, severe pharyngotonsillitis and cervical adenopathy can be observed. This constellation of signs and symptoms may suggest an infection with one of the following pathogens: adenovirus, influenza viruses A or B, enteroviruses, Epstein-Barr virus, herpes simplex viruses type 1 and occasionally type 2 or primary HIV infection.^{6,7,8} The pharyngotonsillar findings classically include tonsillar enlargement with evidence of acute inflammation such as erythema, exudate, palatine petechiae, vesiculopustular lesions and/or ulcers. The anterior cervical lymph nodes are often moderately enlarged, firm and may or may not be tender. A maculopapular rash is not an uncommon presenting feature with either syndrome.

Although these signs and symptoms often overlap between different causes of throat infection, the presence or absence of some of these findings can provide clues to the diagnosis of specific

conditions. When the latter picture is associated with conjunctivitis or otitis media, the diagnosis of pharyngoconjunctival fever secondary to adenovirus is highly likely. Adenovirus is implicated in pharyngitis in children as often as 15–23 percent.⁷ The presence of ulcerative lesions on the erythematous base on the posterior palate is associated with Coxsackie A viral throat infection, a condition known as herpangina. Another variant of Coxsackie pharyngitis is hand, foot and mouth disease. Small vesiculopustular lesions or shallow ulcers are seen on the soft palate, palms and soles. The association of significant cervical or generalized adenopathy and hepatosplenomegaly is highly suspicious for infectious mononucleosis due to Epstein-Barr virus or less commonly due to cytomegalovirus. Acute pharyngitis is recently described as part of the acute retroviral syndrome secondary to HIV. Fever, sore throat and a mononucleosis-like syndrome in conjunction with the usual risk factors for HIV can suggest the diagnosis. Early recognition and initiation of antiretroviral therapy is recommended.⁹

BACTERIAL PHARYNGITIS OTHER THAN GABHS

Many bacteria other than GABHS are associated with pharyngitis including non-group A β -hemolytic streptococci (NGABHS), *Arcanobacterium haemolyticum*, *Neisseria gonorrhoeae*, *Mycoplasma pneumonia*, *Chlamydia* spp., *Corynebacterium diphtheriae* and others.

Non-group A β -hemolytic streptococci, particularly Lancefield groups C (GCS) and G (GGs), have been implicated as causes of acute pharyngitis in children^{4,5, 10-14} and adults.¹⁵ Certain species (large colony isolates; *S. dysgalactiae* susp. *equisimilis*) of GCS and GGS are termed "pyogenes-like" because they share multiple characteristics with group A streptococci, including streptolysin O, hyaluronidase, DNAase, streptokinase and M proteins.^{8,16-18} These organisms have caused well-documented epidemic outbreaks (often food-borne) of pharyngitis.^{7,8,10} Their role as causes of endemic pharyngitis in children remains unclear^{10, 19-22} partially be-

Table 1. Pharyngitis - Etiology

Bacteria	Viruses
Group A β -hemolytic streptococci	Rhinoviruses
Group C&G β -hemolytic streptococci	Coronaviruses
(Large colonies; <i>S. dysgalactiae</i> susp. <i>equisimilis</i>)	Parainfluenza viruses
<i>Arcanobacterium haemolyticum</i>	Enteroviruses
Mixed anaerobes	Influenza A and B
<i>Mycoplasma pneumoniae</i>	Adenovirus
<i>Chlamydia pneumoniae</i>	Epstein-Barr virus
<i>Neisseria gonorrhoeae</i>	Herpes simplex 1 and 2
<i>Corynebacterium diphtheriae</i>	Cytomegalovirus
<i>Corynebacterium ulcerans</i>	HIV
<i>Yersinia enterocolitica</i>	
<i>Yersinia pestis</i>	
<i>Treponema pallidum</i>	
<i>Francisella tularensis</i>	

pected. This infection may present as sore throat and ulcerative pharyngotonsillitis but is often asymptomatic. *Mycoplasma pneumoniae* and *Chlamydia* spp. have been implicated as causes of pharyngitis. The difficulty in correlating the serologic and microbiological findings to the clinical picture limits the understanding of the role of these two microorganisms in pharyngitis.^{7,8}

cause GCS and GGS are frequently isolated from asymptomatic individuals. However, evidence is accumulating in adolescents that strongly supports GCS and GGS as causative agents.²³⁻²⁶ Many adolescent and adult patients experience clinical disease that is similar to GABHS pharyngitis.²⁵ Acute rheumatic fever is not a sequel of GCS and GGS infections although glomerulonephritis following upper respiratory tract or skin infections with GCS has been reported.⁸ Our group recently completed a pilot study²⁷ examining the role of GCS and GGS in endemic pharyngitis, and a large multi-site study is currently in progress.

The majority of GCS and GGS are susceptible to penicillin, erythromycin and cephalosporins. The need for treatment of pharyngitis caused by these organisms is unclear. Many practitioners treat patients who have persistent symptoms after the culture result is obtained; however, evidence that treatment provides symptomatic relief needs to be established.

Arcanobacterium haemolyticum, a Gram-positive rod, is an uncommon cause of pharyngitis affecting mostly adolescents and young adults. Infection closely resembles GABHS pharyngitis with lymphadenopathy, pharyngeal erythema, exudate and most notably a scarlatiniform rash in many patients. Erythromycin is the drug of choice and may shorten the duration of illness.^{7,28}

Pharyngitis due to *Neisseria gonorrhoeae* is rare. In children, sexual abuse must be sus-

GABHS PHARYNGITIS

Clinical Features

GABHS pharyngitis is a common childhood illness. It is usually encountered in late winter and early spring. Identifying and treating GABHS infection is the primary goal of clinicians evaluating children with signs and symptoms of pharyngitis. This stems from the well-recognized fact that antibiotic treatment of GABHS pharyngitis is preventive of suppurative complications and, more importantly, of rheumatic fever.²⁹⁻³² In addition, early treatment of GABHS pharyngitis shortens the course of the disease.³³

Many clinical signs and symptoms are recognized to be associated with GABHS pharyngitis in children. These include sudden onset of fever and sore throat in a school-aged child. Fever is often low grade or absent. Occasionally, headache, vague abdominal pain, nausea or vomiting is noticed. The parent may agree that the child has had halitosis since the onset of the illness. The pharynx is erythematous and the tonsils are enlarged. Significant submandibular lymphadenopathy and the absence of coryza and cough are characteristic. Occasionally, tonsillar exudate, palatine petechiae and nasal excoriation are noticed. Nasal excoriation is rare but more common in the younger child. Scarlatiniform rash, an erythematous, fine, sandpaper-like exanthem that generally appears in the axillary and inguinal folds before it is

generalized, is pathognomonic for GABHS infection and also is rare.

These signs and symptoms are often absent and do overlap with those seen with pharyngitis from other etiologies.³⁴ This acute condition usually results in a prompt visit to the physician. The absence of the classical signs and symptoms is possibly due to early presentation in the course of illness. Some of the same signs and symptoms are seen in adults and children at different rates. For example, fever and pharyngotonsillar exudate are more common in adults than children. It is due to the above reasons that the clinical diagnosis is difficult. Generally, clinicians tend to overdiagnose this condition.³⁵ Since the early 1950s, the common approach to suspected GABHS pharyngitis is to obtain a throat culture^{36,37} and, more recently, rapid antigen test if available.

Laboratory Diagnosis of GABHS

Laboratory diagnosis of GABHS has many limitations. Throat cultures have a relatively high incidence of false-negative rate (10 percent-20 percent)³⁸⁻⁴¹ A positive throat culture for GABHS, without serologic evidence, does not distinguish between a carriage state and an acute infection.^{42,43} Serologic testing is impractical in the evaluation of suspected acute GABHS pharyngitis. Rapid antigen tests by a reference laboratory method can be highly sensitive; however, the sensitivity varies widely depending on the practice.⁴¹ Hence, the American Academy of Pediatrics recommends its use only in conjunction with throat cultures.⁴⁴ On the other hand, culture confirmation of negative high-sensitivity rapid antigen tests is found to be not cost effective.⁴⁵

Other limiting factors for throat cultures are its logistics. Providing patients with throat culture results and prescribing or discontinuing treatment are time consuming and difficult particularly in an unreliable patient population.

Current Practices

The experts maintain that the diagnosis must rely on bacteriologic confirmation.^{6-8,46} Many

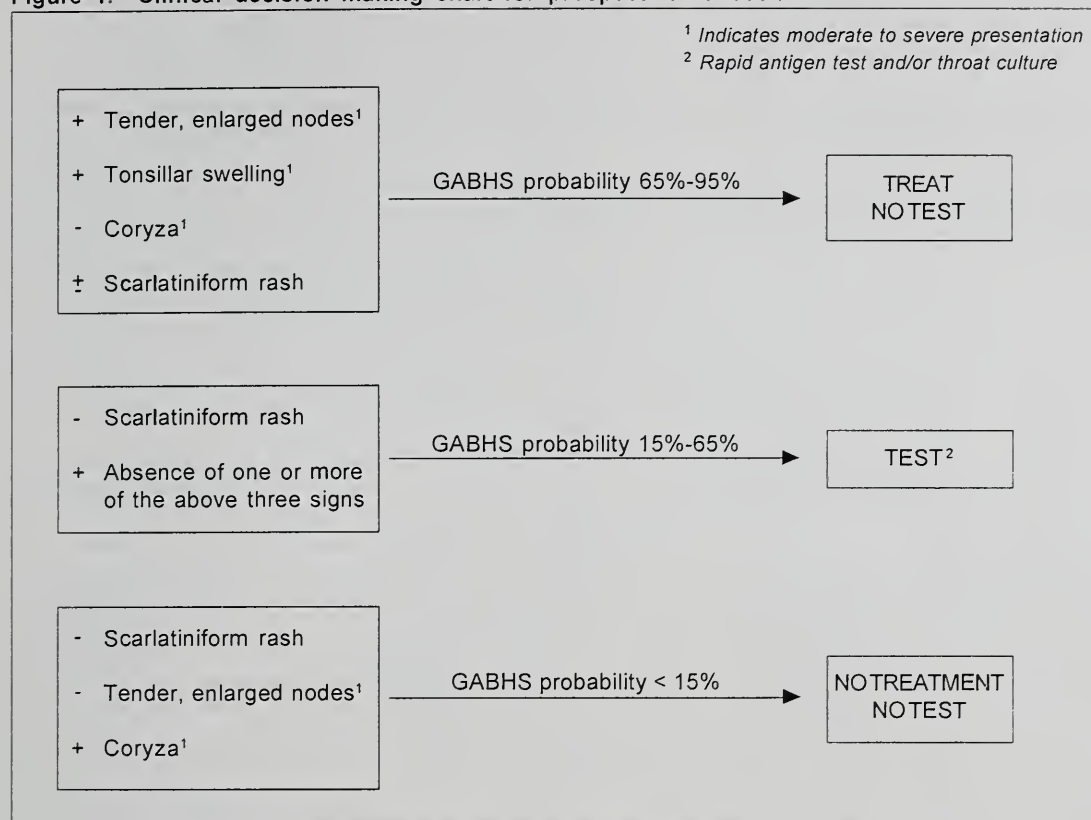
clinicians rely on rapid antigen detection test despite its variable sensitivity. Others are utilizing the standard throat culture. Some await the culture results and treat those with positive cultures only. Most begin antibiotic therapy at the initial visit. In one report, 83 percent of patients were placed on antimicrobial therapy at the initial visit but only 40 percent were asked to discontinue antibiotics after a negative culture.⁴⁷ In another report, 73 percent of the pediatric encounters with pharyngotonsillitis received antibiotics without any diagnostic test for GABHS.⁴⁸ These difficulties in clinical and laboratory diagnosis of GABHS pharyngitis support the argument some emergency physicians have for the empirical antimicrobial therapy for patients with "reasonable" risk for this type of infection.⁴⁹ Yet, unnecessary treatment carries a risk for complications without therapeutic benefit⁵⁰ and would compound the problem of antimicrobial resistance.

Predicting the Diagnosis

Many algorithms and scores have been devised in an attempt to increase the clinical accuracy of the diagnosis of GABHS pharyngitis in children. However, the utility of these clinical tools has been limited, perhaps due to their complexity.⁵¹⁻⁵⁵ On the other hand, much simplified clinical guidelines, such as the ones produced by the World Health Organization, have been shown to have low sensitivity.⁵⁵ In an earlier study, we derived predictive models for GABHS. In these models, in the absence of coryza and the presence of moderate to severe tonsillar swelling and moderate to severe cervical lymphadenopathy with or without scarlatiniform rash, the risk for GABHS is greater than 65 percent. Conversely, in the presence of coryza, absence of scarlatiniform rash and moderate to severe lymphadenopathy, the risk for GABHS is less than 15 percent. In our study population, there was no significant difference in the incidence of the disease between children less than five years of age and those who were older. These models were incorporated into a simple, non-age dependent clinical decision-making chart, Figure 1.⁵⁶

Clinical decision roles for GABHS pharyngitis in adults have been validated. Centor found that

Figure 1. Clinical decision making chart for prospective validation.



fever, exudate, cervical adenopathy and lack of coryza had a 55 percent predictive ability for the diagnosis.⁵⁷ In a recent study using the Centor model applied to patients between 4 and 60 years of age, the sensitivity and positive predictive value of rapid antigen tests were significantly higher in patients older than 15 years of age with three or more features but not in children 4-14 years.⁵⁷ This could be explained by the findings in three current pediatric studies where fever and exudate were not found to be significantly associated with GABHS pharyngitis in children.^{51,52,56} One can postulate that if a children-specific clinical-decision chart (Figure 1), is used in conjunction with the rapid antigen detection test, its sensitivity and positive predictive value will also be significantly higher in this age group.

If prospectively validated, using the clinical-decision making chart, children presenting with suspected GABHS pharyngitis can be divided into three groups based on their risk for positive throat culture: A high risk group, probability

greater than 65 percent, a moderate risk group, probability between 15 percent and 65 percent, and a low risk group, probability less than 15 percent. These models could be integrated into a consistent treat, test, no treatment/no testing approach to the clinical management of childhood pharyngitis in a practice setting where follow up is problematic or where confirmatory tests are not readily available. In theory, using this model would significantly improve the prediction of both positive (greater than 65 percent) and negative (less than 15 percent) diagnosis of GABHS over the common teaching that this diagnosis is made accurately, clinically, in only 50 percent of patients. Moreover, using these models in conjunction with rapid antigen detection may enhance its sensitivity and positive predictive value. Enhancing the sensitivity of the rapid antigen detection test would possibly change the current recommendations, practices and clinicians compliance with guidelines.

Treatment of GABHS

The mainstay of treatment of GABHS pharyngitis is penicillin. Resistance to penicillin has never been documented. It is least expensive and has a proven efficacy. Oral penicillin V, or a penicillin derivative such as amoxicillin, is most often used. The recommended dose is 40 mg/kg/day for ten days. While the symptoms

improve rapidly, it is imperative to emphasize the importance of completing the entire ten-day period of therapy. If compliance is in question, intramuscular benzathine penicillin G (.6-1.2 million units) is the alternative.⁵⁹

In penicillin allergic patients, macrolides, cephalosporins and clindamycin are excellent alternatives.

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Micro-Deletion Detected by Fluorescent *in situ* Hybridization for Williams Syndrome

Kapal Dewan, MS, CLsp(CG)¹ — Digamber S. Borgaonkar, Ph.D.^{1,5}
Louis E. Bartoshesky, M.D., M.P.H.^{2,4} — Deborah Tuttle, M.D.^{3,4}

Williams syndrome is a multiple congenital anomaly syndrome first described in 1961.^{1,2} Among the common features of this syndrome are: characteristic "coarse" facies including medial flare to the eyebrows, short palpebral fissures, depressed nasal bridge, epicanthal folds, fullness of periorbital subcutaneous tissues, full lips, blue eyes with stellate pattern in the iris; cardiovascular anomalies including supraaortic stenosis, peripheral pulmonary stenosis and atrial or ventricular septal defect identifiable in infancy with renal artery stenosis and other arterial anomalies in adulthood; developmental delay/mental retardation. (The mean IQ is reported to be in the mid to high 50s, though children with Williams syndrome tend to have levels of language ability greater

than their overall cognitive ability). A number of other anomalies may be seen as well. Recently, Williams syndrome has been identified as being associated with a heterozygous micro deletion on chromosome 7q11.23. Williams syndrome can now be confirmed using fluorescent *in situ* hybridization (FISH).

FISH is a technique which may be used to identify small, usually submicroscopic, chromosomal deletions.

A fluorescently labeled polynucleotide is generated that is complementary to a segment of nucleotides at the chromosomal site. (For Williams syndrome, the site is on chromosome #7, the long arm at the 11.23 segment.) Chromosome preparation is carried out and the chromosomes are exposed to the fluorescently labeled polynucleus (probe). After an appropriate time to permit hybridization, the preparation is reviewed. All #7 chromosomes with the intact

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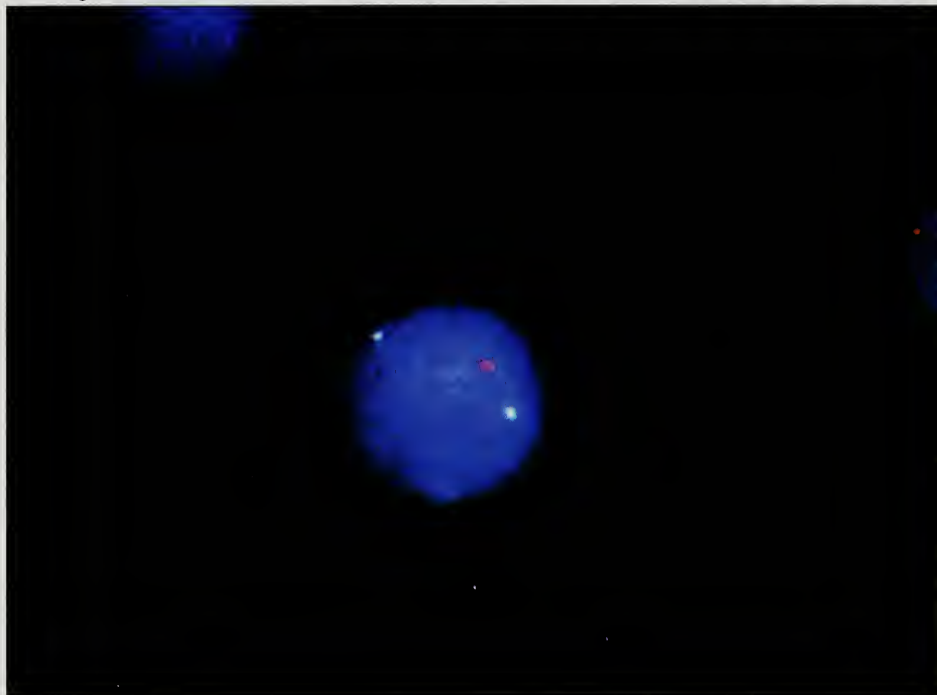
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Figure 1. Fluorescent *in situ* hybridization (FISH) results showing the deletion in Williams Syndrome patient. One chromosome 7 shows both the red and green (control) signal. The deletion is indicated on chromosome 7 which is missing the red signal. Also shown is the interphase nucleus with one red signal present.



locus will show up fluorescing while a chromosome 7 with the q11.23 deletion will not fluoresce. (See Figure 1)

CASE REPORT

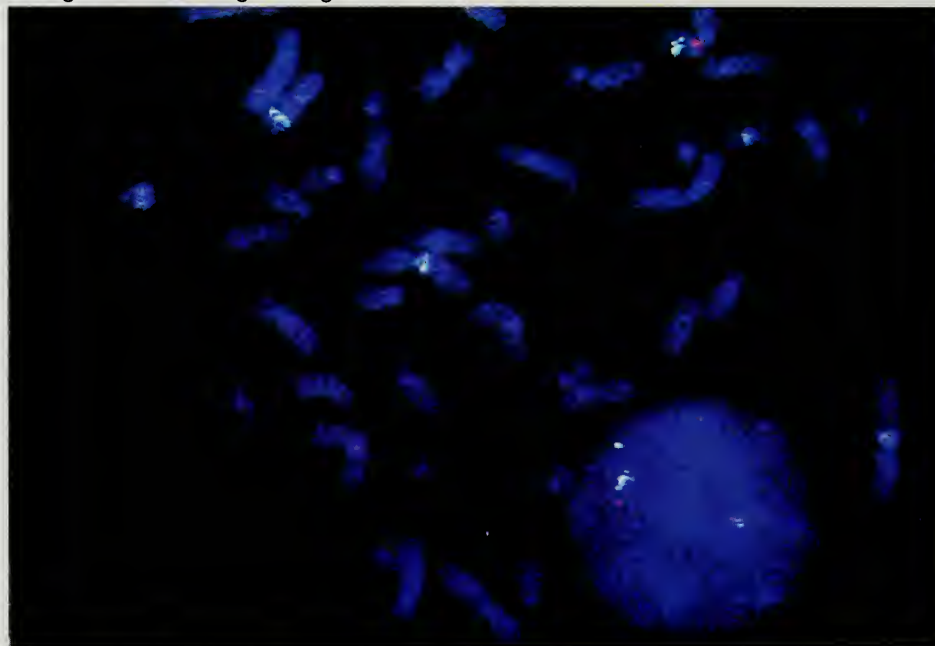
Baby Boy R was born at about term to an 18 year old gravida one para one woman. Pregnancy was complicated by diagnosis of bipolar disorder in the mother. The mother had been treated with Lithium in the past but probably had discontinued this by the time of conception. There was a history of maternal cigarette smoking and previous sexually transmitted disease apparently treated appropriately. Family history

was negative for multiple congenital anomaly syndromes, mental retardation, congenital heart malformation, or infant death.

At birth the baby weighed 2074 grams with a head circumference of 32 cm and a length of 46 cm. The facies were coarse with puffy eyelids, full lips, medial flare to the eyebrow, depressed nasal bridge, trace epicanthal folds, and anteverted nares. The ears were posteriorly positioned and low set with hypoplasia of the helical folds superiorly. There was a harsh systolic murmur. Subsequently, he

was identified as having a ventricular septal defect with transposition of the great vessels.

Figure 2. Image of a metaphase cell hybridized with the Vysis Williams Syndrome Region DNA FISH Probe (Spectrum Orange LSI Elastin gene region with Spectrum Green LSI D7S486/D7S522 Control Probe). Note the absence of the Spectrum Orange LSI Elastin gene signal on Chromosome 7.



Neurologic examination showed no focal findings but generalized hypertonicity. The baby had been intubated in the delivery room and when he was extubated he developed stridor. Subsequent airway evaluation showed a laryngeal anomaly.

Blood was sent for cytogenetic and FISH studies. In the cytogenetic laboratory, three cultures were set up (5 mL media, 0.1 mL PHA, and 0.5 mL blood). Cultures were incubated for 48 hours and then harvested. Slides were made and aged in a microwave. Slides were then cooled to room temperature, stained (GTL) and analyzed. BBR had an apparently normal 46,XY karyotype. FISH studies using a specific DNA probe for the Williams syndrome locus at 7q11.23 documented the presence of that deletion on one of the #7 chromosomes. (Figure 2)

DISCUSSION

FISH is a technique of the 1990s.³ Specific probes are available for a number of multiple congenital anomaly syndromes including Will-

iams, Prader-Willi, Angelman, Rubenstein-Taybi, Miller-Dieker, Smith-Maginnis and others. Probes are also available for each chromosome long and short arm and for a large number of polymorphisms on each chromosome.⁴ Duplication of part or all of any chromosome can be identified with this technique. FISH is also of value in cancer cytogenetics for identifying specific small chromosomal deletions in certain tumors. It is of particular value when one of the syndromes known to be associated with a small deletion is suspected clinically. The syndromes can then be reliably identified using this technology.⁵

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The Protein Controversy: What to Tell Your Patients

Council on Nutrition Sciences and Metabolism

G. Stephen DeCherney, M.D., M.P.H.

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High protein/high fat/low carbohydrate diets have attracted advocates intermittently for most of this century. The obesity epidemic has coincided with an economic boom in this area as expensive high protein/high fat diets have experienced an explosive increase in popularity. These diets are known by many names: Atkins diet, Zone diet, sugar-busters diet, etc. All make similar promises, despite assuming slightly different marketing demeanors. Arguably these diets are safe in healthy individuals, but the question of whether these diets are safe for diabetic patients was discussed during the 59th Annual Scientific Sessions of the American Diabetes Association.

Three of the foremost experts in diet therapy for diabetes, Marion Franz, and Drs. Mary C.

Gannon and Frank Q. Nuttall, presented their collective views on the high protein/high fat craze. They attempted to answer three questions: what should primary care physicians tell their type 1 diabetic patients regarding daily protein intake; what dietary recommendations should be made to type 2 diabetic patients; and what advice should be given to diabetic patients contemplating a radical high protein/high fat/low carbohydrate diet?

DIETS OF 1909 COMPARED TO 1994

Ms. Franz reviewed data about the eating habits of Americans. It may be either reassuring or disturbing to note that in this century Americans have barely changed the proportion of protein, fat and carbohydrates they consume each day.¹

G. Stephen DeCherney, M.D., M.P.H., is the editor of the Delaware Medical Journal. He also practices endocrinology in Wilmington and Newark, Delaware.

Despite changes that have occurred in physician attitudes from 1909 through 1994, consumption of protein has constituted approximately 11 percent, carbohydrates have varied from 48-55 percent, and fat ranges from 31 percent to a high of 40 percent in 1970. In the last two decades, the percentage of fat consumed has diminished slightly. Additionally, there is little data to support current medical dogma.

Doctors often recommend that bedtime snacks contain protein; that protein accompany fruit or "sweets"; that patients should eat some protein after treating a hypoglycemic reaction with "fast-acting" glucose; and that protein will have less impact on blood glucose levels than carbohydrate. There are few studies that either support or contradict these dicta.

In fact, when doctors recommend protein, in most cases they are also recommending fat. Table 1, adopted from Ms. Franz's presentation, makes this point quite clearly.

STUDIES ON PROTEIN CONSUMPTION

There have only been two studies investigating the effect of protein consumption on patients with type 1 diabetes. In a study conducted by Peters et al., type 1 diabetic patients had their glucose levels clamped at approximately 6.8 mM.² Blood glucose samples, which were measured for five hours after either a standard meal, a standard meal plus extra protein, or a standard meal plus extra fat, revealed very little difference in the glucose curves.

Table 2.

	gm/kg-day	% energy (2000 kcal diet)
Minimum for N balance	0.6	8%
US RDA	0.8	11%
US consumption	1.2	15%

Table 1.

Food	Protein (calories)	Fat (calories)
Beef bologna, 1 oz slice	12	75
Cheese, 1 oz slice	28	85
Peanut butter, 2 tbsp	32	144
Hot dog	28	147
Beef jerky	64	50
2% milk, 8 oz	32	42

The peak of the glucose level was slightly delayed in the meal plus extra fat group. Investigators in the other study intentionally made type 1 patients hypoglycemic and then treated them with either carbohydrate alone or carbohydrate with protein.³ The patients' glucose recovery was similar, but the regimen with protein added unneeded calories.

HIGH PROTEIN DIETS: PROS AND CONS

Regarding high protein diets, Ms. Franz suggested that protein is a stronger stimulus to insulin secretion than carbohydrate, contrary to what is stated in many lay articles. In theory then, high protein/low carbohydrate diets may worsen hyperinsulinemia.

She noted, however, that high protein/high fat diets have some advantages. First, the diets are simply lower in calories. Second, the diets are lower in carbohydrates, so glucose levels fall. Third, these diets induce ketosis and consequently appetite is suppressed. Fourth, there is loss of the water-weight that accompanies a reduction in carbohydrate consumption.

Unfortunately, there are many disadvantages to these diets. There are many nutrients in grains, fruits, vegetables, and in carbohydrate-laden foods. The fat associated with high protein diets is often saturated fat. These diets are extremely difficult to con-

tinue beyond a few months. And finally, there are no peer-reviewed studies comparing the benefits of high fat to other more conventional regimens.

TOO MUCH PROTEIN?

Dr. Gannon reviewed the scientific literature about protein content of various human diets. She established parameters for the minimum daily protein consumption. (Table 2)

She then described diets of unusual cultures in which large amounts of very lean protein were consumed. In one case, the diet was 80 percent protein. Too much protein may cause lethargy and malaise even in isocaloric diets that replace some of the protein with carbohydrate. According to Ms. Franz, less than 40 percent of the calories should be derived from protein.

Drs. Gannon and Nuttall reported data from experiments in which either 50 grams of beef protein or 50 grams of water were ingested. The glucose values following each were indistinguishable. Alpha-aminonitrogen begins to rise one hour after ingestion of 50 grams of beef protein and peaks at about two hours. The alpha-aminonitrogen levels had returned to baseline in approximately seven hours.

SUMMARY

Contrary to physician training, there is very little data to support any specific dietary recommendations to patients other than those put forth by the American Diabetes Association. In the absence of such data, physicians should probably refer their patients to Aristotle, who suggested that everything be done in moderation.

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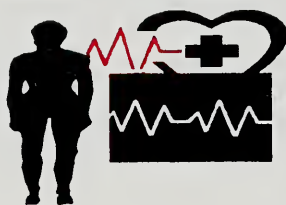
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On The Cover . . .

The Lamps of Tiffany: Highlights from the Egon and Hildegard Neustadt Collection will be on view at the Delaware Art Museum through March 5, 2000. The exhibition provides an overview of the incomparable achievements in glass by the Corona, New York, workshops of the Tiffany Glass and Decorating Company. Included are more than 45 examples of Tiffany lighting, including desk, table and floor lamps as well as chandeliers and two leaded glass windows. The selection profiles the inventive approach to lamp design by one of America's premier Aesthetic Movement decorators, Louis Comfort Tiffany (1848-1933). The works represent the diverse styles and pioneering glass techniques for which the firm is best known. The beauty and fine craftsmanship of the works demonstrate Tiffany's intention to attain the same status for decorative objects as that given to the fine arts.



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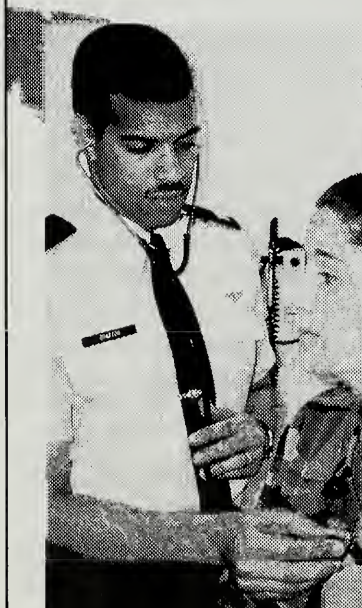
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Our Scientific Past

Peter V. Rocca, M.D.

I read Dr. DeCherney's editorial "The Complementary Side of Complementary Medicine" in the October issue of the *Delaware Medical Journal* with a mixture of sadness, interest and dismay. I fear that the firm scientific basis upon which Medicine has rested for the past 150 years is being eroded by the political and financial pressures of the current health care climate.

In 1847, a noble physician by the name of Nathan Davis founded a noble organization, the American Medical Association. The original mission of the AMA was an equally noble one, viz. "to rid the United States of snake oil salesmen." I would submit to the reader, as evidenced by the recent turn of events in this country, that in this the AMA has failed. "Snake oil" sales not only abound today but are proliferating at an

alarming rate. A stroll through any mall in any state will reveal a GNC (General Nutrition Center) whose isles are stocked with jars and jars of pills whose labels make health promoting claims unsubstantiated by anything even remotely resembling a double blind, placebo controlled trial. Happy Harry's, Acme supermarkets, and the like, not willing to miss out on this lucrative market, have followed suit and have stocked their shelves with the same pills. And so, the people of this great society, who Medicine cannot cure and are afflicted with chronic conditions, willingly plop down fist fulls of cash in an attempt to restore health. What has the medical establishment done in response to this? Followed Nathan Davis' example? Hardly has it done so. Instead, we legitimize the use of "natural" supplements by using politically correct terms, such as "complementary" medicine in describing the process. Who ever decided that the use of things like St. John's wort and shark

Peter V. Rocca, M.D., practices rheumatology in Wilmington, Delaware. He is an Associate Editor for the Delaware Medical Journal.

cartilage were complementary to modern medical therapeutics?

The National Institutes of Health have established a center to help study the efficacy and safety of natural supplements. The problem is that the list of these supplements is almost endless and the funds needed to adequately evaluate a therapeutic intervention are formidable. In the meantime, the U.S. taxpayer foots the bill. Dr. DeCherney points out that here in Delaware, a committee has been established at Christiana in order to help identify which of these supplements should be on the hospital formulary. One would hope that the impetus of these measures, both the NIH center as well as the Christiana Complementary Medicine Assessment Committee, is the pursuit of knowledge and the advancement of science. Unfortunately, both political pressures and the need to remain financially competitive in an environment of ever decreasing reimbursement may also be playing a role. The Christiana committee has a daunting task, and I do not envy the members of that committee to find hard, convincing data among the scattered reports present in the literature.

Dr. DeCherney proposes that such lack of data is due to the manufacturers' limited resources. I would submit that the real reason rests more in the inability to obtain a patent on any substance extracted from nature, the impotence of the FDA in this arena, and the resultant lack of necessity to do properly controlled studies prior to bringing a natural product to market. Furthermore, these manufacturers, freed from the "encumbrances" of research and development, are able to make quick and easy profits from their products. Consider the amount of money that it takes to produce 150 capsules of glucosamine (ground up bovine cartilage) and chondroitin sulfate (ground up crab shells). Now

consider the profit when these 150 pills, less than a month's supply, are sold to senior citizens at \$29.95. These manufacturers are doing quite well. Dr. DeCherney wishes to remind us that such beneficial agents as aspirin and digitalis were extracted from nature, the willow bark and the foxglove plant, respectively. This is considered evidence that therapeutic bounties are to be found in nature. I cannot disagree. But how long has Medicine known about the advantages of aspirin and digitalis? Over two hundred years of use honor these compounds. Were our physician ancestors "asleep at the wheel," ignoring other miraculous substances that could have made a significant impact on human suffering? I don't doubt that something like Echinacea and saw palmetto can make some impact on the symptoms of a viral URI or prostatic hyperplasia, but how clinically significant an impact? Will the urologist's prostatectomy be cast aside or substantially postponed?

It is unquestionable that our patients use natural supplements and will continue to do so. Thanks to Madison Avenue, our society believes that if something is "natural" it will restore health and rejuvenate. It is therefore imperative that we physicians educate ourselves on these supplements so that we may answer questions appropriately. We must always be advocates of our patients and recall that many that come to see us are on a fixed income and cannot easily afford expensive therapeutics. This fact becomes even more significant when such therapeutics are of dubious efficacy and unknown safety. We, the descendants of Nathan Davis, must never cease to endeavor to find those agents which help to alleviate human suffering and restore health. And we must never cease to endeavor to rid this country of snake oil salesman even if it is politically unfavorable and financially disadvantageous.

Coordination, Cooperation and Networking Lead to Success

Robby Chabalko, MSD Alliance Member

In this era of busy family life, many organizations, which rely on volunteers to provide service, are suffering. Model paradigms for volunteers, which had been useful are no longer so successful. With many more spouses working full time, there are fewer volunteers available for projects.

It is the responsibility of the health care community to address social problems and provide leadership to coordinate and network among volunteers who can provide service. Current alliance members want to provide service, want their service to make a contribution, and want to see results. Taking these factors into account, the Delaware Medical Alliance recently tried a new venue for service based on coordination, cooperation, and networking. It involved the children and grandchildren of physicians, their friends, and other community volunteers rather than just Alliance members.

For the past several years, the American Medical Association Alliance (AMAA) has designated the second Wednesday in October as the day to "Stop America's Violence Everywhere" or SAVE Day. The focus is to bring public attention to the growing role that violence plays in our society. State health projects chair, Sue Saliba, the wife of surgeon Anis Saliba, asked each county to promote SAVE Day. She obtained copies of an anti-violence film, "The Dating Bill of Rights," to be shared with local high schools throughout the state. This film addressed problems confronting teenagers when they fail to understand their rights in dating situations. Additionally, in Sussex County, Sue arranged for an exhibition of the Silent Witness Program to be shown in the lobby of Beebe Hospital. This powerful exhibit commemorates the Delaware victims of domestic violence by telling their stories. Sue reserved this exhibit through the Domestic Violence Coordinating Project. Visitors to the hospital were given suggestions for providing help,

which could make a significant difference in the lives of potential victims. Emergency Room personnel wore special Alliance "Hands Are not For Hitting" T-shirts, to focus attention on this special day.

In New Castle County, health projects chair, Goldie Klein the wife of pediatrician Gershon Klein, determined that the Alliance wanted to focus on children. It was decided that a program promoting peaceful conflict resolution among young children could make a lasting contribution that might have long reaching effects. In addition, this SAVE day promotion could be coordinated with the YWCA's Week Without Violence which combined the efforts of over 50 local organizations to bring public attention to this community problem. It also had the added benefit of reinforcing for the public that physicians are concerned about the growing role of violence in our society.

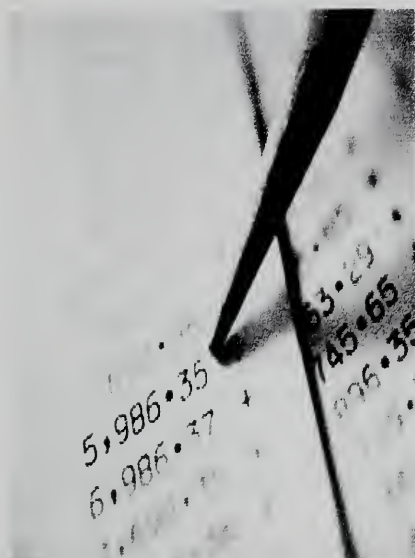
The AMAA has a national children's program entitled "Hands Are Not for Hitting." They have also published written materials in the "I Can Choose" series which illustrates for children that violence does not have to be an option. Life is all about making choices and children can learn to choose to settle disagreements without physical force. Goldie brought together a member group of former teachers (Helen Geimeier, Georgia Brereton, and Robby Chabalko) as well as the creative talent of her daughter-in-law, Lynn. It was decided that a puppet show might be the best way to reach young children. The group decided to write a short one-act play to show that talking provides a more effective means of problem solving, than hitting. The YWCA's Community Anti-Violence Fair in Christiana Mall would be the proper venue for this show.

New Castle County president, Linda Panzer, encouraged the group. Goldie located a puppet theater; member Nanci Newcomb provided puppets, which represented the diverse population of children in a neighborhood. Member Dorothy

Pecora created two more puppets to round out the cast. In addition to the puppet show, copies of two coloring books from the "I Can Choose" series were located in Sussex County, and T-shirts and placemats illustrating "Hands Are Not for Hitting" were also found. More T-shirts were needed to make this project a success. The New Jersey Alliance had been the originator of the "Hands Are Not for Hitting" motto. Goldie contacted them to see if any more T-shirts were available. This contact led her on a treasure hunt. She talked to the former health projects chair for New Jersey who knew that the Medical Society County of Ulster New York Alliance had a large supply of T-shirts left over from a health promotion. Goldie then contacted their past health chair, Elizabeth Anderson, who was delighted to share the shirts with Delaware. There was no charge, just a lot of good wishes. The AMAA provides a vast network of resources available to help. Physician spouses throughout the country address similar community problems. It is through this networking that much can be accomplished.

The group decided to use the placemats as a pledge with a place for each child's "signature" to reinforce the idea that the kids, with their parents and /or care-givers as witnesses, should make a conscientious effort not to use violence to solve problems. Goldie's son, Philip, made three house calls to help her hone her computer skills to print the pledge on the placemats to match the colorful decorations, turning the placemats into a certificate the children could display.

On the day of the event many volunteers (which included the children and grandchildren) of physicians helped make the effort a very big success. A special thank you goes to college student Rob Panzer who was a puppeteer extraordinaire and quite popular with the children. More than one hundred children benefited that day. In addition to learning that "Hands Are Not for Hitting" the children and their parents learned that physicians do care about the quality of life in our community.



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To: Medical Professional
From: Ken J. Musi
Re: Health Care Real Estate in Delaware

Within the field of medicine, physicians specialize in order to best meet the medical needs of their patients. As a commercial real estate agent, I have done likewise for equally important reasons. By becoming an expert in the field of real estate specifically suited for the Health Care industry, I have helped hundreds of physicians and medical groups acquire, sell or lease space appropriate for medical practices and health related facilities.

Since beginning my career in 1989, I have built a client base that has come to value the knowledge and expertise that I have acquired through this specialization in real estate. Many Physicians, Residential real estate agents, attorneys, accountants, and other Commercial real estate agents also recognize the importance of such a specialty, with much of my business resulting in referrals from this important professional network. Some of my clients have included: Blue Cross Blue Shield of Delaware, the duPont Hospital for Children, St Francis Hospital (Franciscan Family Care), Riverside Hospital, Christiana Care, First State Orthopaedics, The Delaware Heart Group, Gastroenterology Associates and many more. In addition, I have also assisted many physicians in finding suitable sites to develop an office building either for their business or for the purpose of investment. Whether assisting physicians just completing residency, or business managers of large practices, my real estate expertise in the Health Care field can be of tremendous value. As a member of the DMGA (Delaware Medical Group Managers Association), I remain involved in the concerns and issues facing the medical community providing an extended benefit to all of my clients.

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Sincerely,



Ken J. Musi



Western Medicine

(edited by Irvine Loudon - Oxford University Press - Oxford and New York - 1997 - 347 pp - \$49.95)

David Platt, M.D.

The editor of this history of medicine, Irvine Loudon, was a practicing general practitioner, and is now a medical historian at Oxford University. Each of the 19 chapters was written by a different individual, some practicing physicians, some medical historians in academia, some in the United States, some in Great Britain.

This book makes no attempt to be encyclopedic and all inclusive. On the contrary, it highlights what the editor thinks are the great moments and movements in the history of medicine. Each chapter is an illustrated essay on what its writer thinks is an important story in that history.

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lin. One chapter covers the social history of medicine and its links to politics, economics, geography, epidemiology, and the health of populations. Another chapter gives the history of medical education as it relates to discoveries in public health, psychiatry, midwifery, genetics, and molecular medicine. Yet another chapter covers current aspects of health including contraception, drug abuse, and AIDS.

Some of the other subjects discussed in depth are the growth of medical education, the birth of the nursing profession, the advent and contributions of the modern hospital, alternative medicine, and, finally, the views of the patient.

This is a fascinating book. It is richly illustrated with 37 color plates, many of which are full page. It has a good glossary and an excellent index. For the busy practicing physician who wants for his bookshelves a text which ties ancient medicine to every day current practice, this is it.

David Platt, M.D., is a retired family practice physician and a member of the Medical Society of Delaware.

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Closing for space reservations is the first of the month, two months prior to publication. Closing for materials is the first of the month, one month prior to publication.

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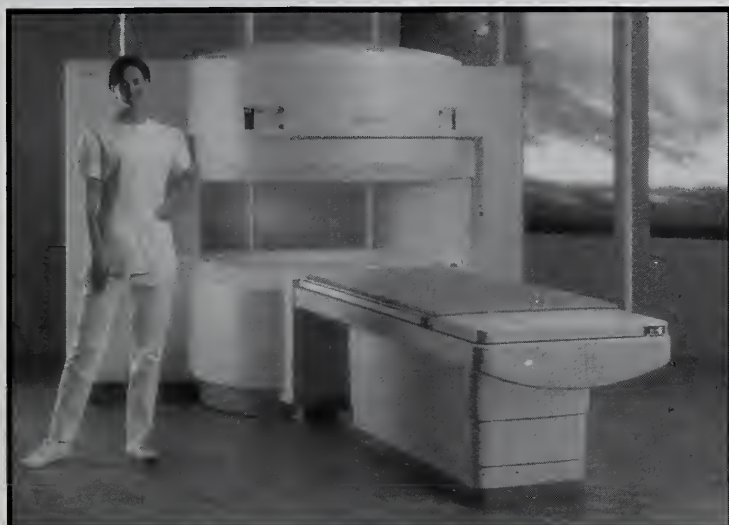
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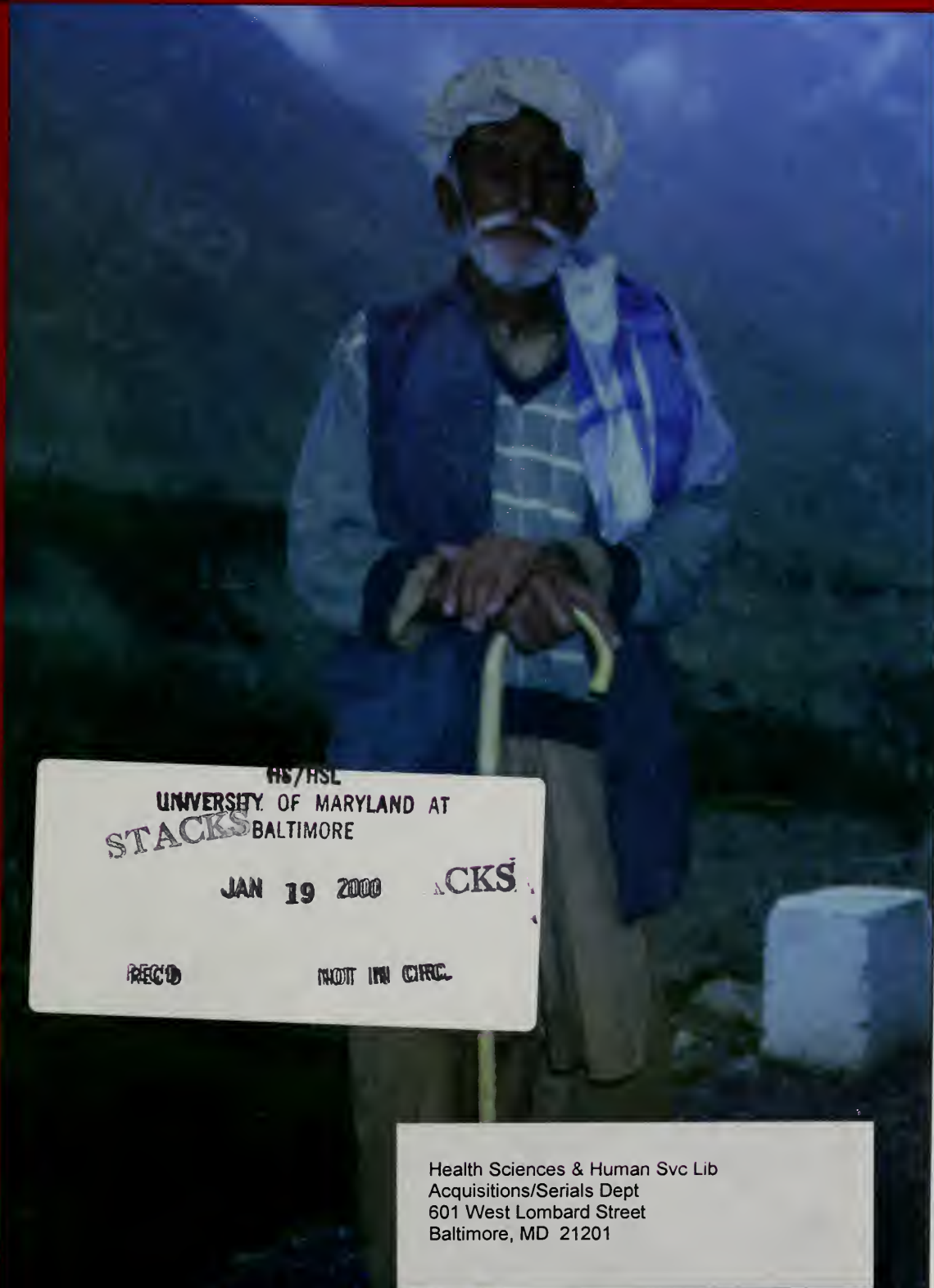
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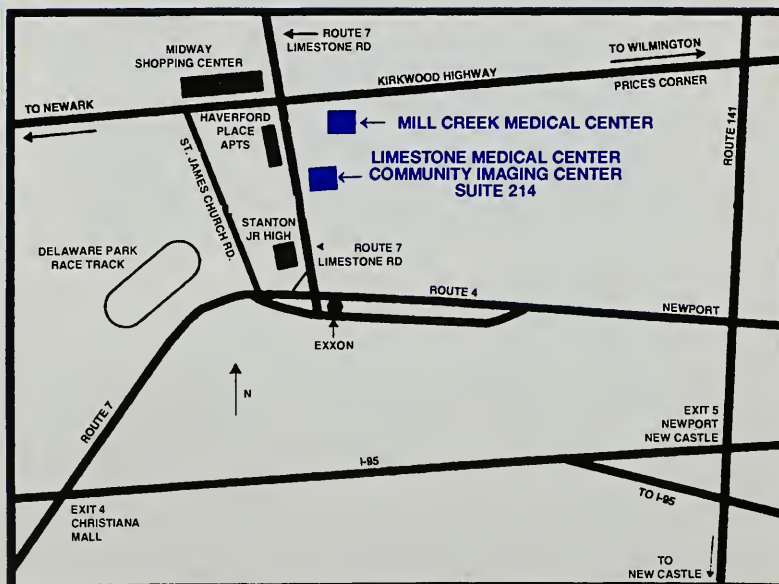
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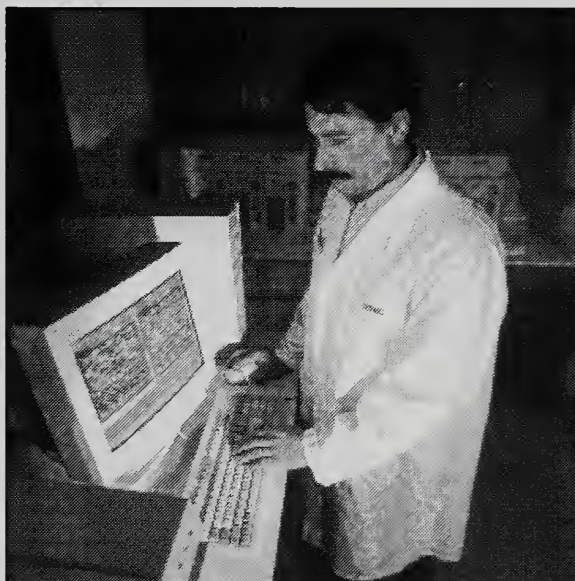
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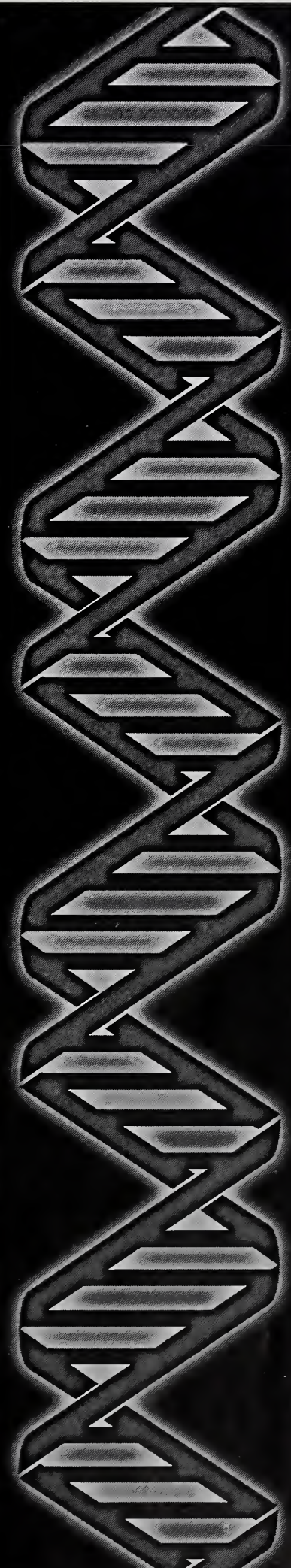
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All material for publication should be submitted on a 3 1/2" computer diskette in Word 6.0. A printout of the manuscript **must** accompany the disk. Manuscripts may also be submitted in paper form (typed or printed out on good-quality paper - one side only, one-inch margins), though computer disk is preferable. The ideal manuscript length is two to 12 pages with up to 12 references, each keyed with superscripts in the text in the order cited. The format should follow that used in the *Index Medicus*. Authors are responsible for the accuracy of the citations.

Graphs, charts and black-and-white glossy photographs are accepted if important to the understanding of the text, but should not exceed four or five pieces. Each should have a label affixed on its back indicating its name, number, and "top." A separate legend should be provided for each. Do not write on the back, or scratch or mar them using paper clips. Do not mount them on cardboard.

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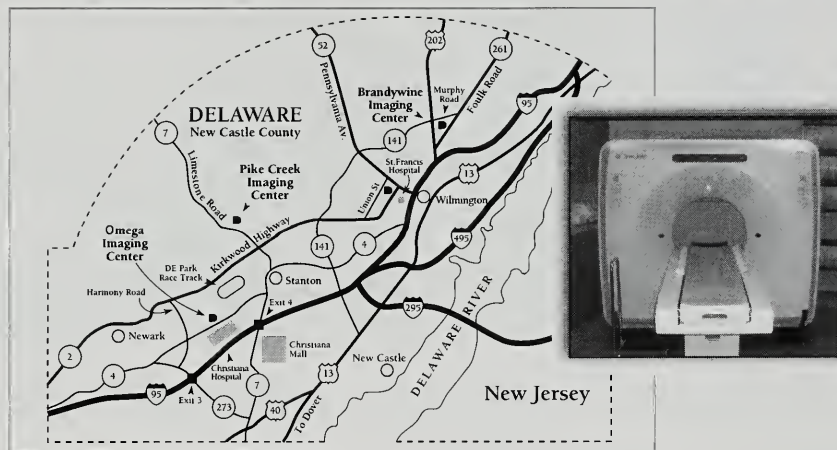
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On the Cover: This man lives in Karimabad in the Hunza district high in the Karakoram Mountains of north Pakistan. In James Hilton's novel, "Lost Horizon," he modeled his Shangri-La after this kingdom known for peace and contentment, where people do not age. The myth probably stems from the National Geographic magazine that stated people there might live to be 120 years old, dining on a diet high in fruits and low in animal fats. The patriarch in this photo claimed to be 60 years old. The AIM doctors who spent the night in his village found no one older!

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Presidential Address

Michael A. Alexander, M.D.

Today I have the honor of addressing you as the new president of the Medical Society. A president who will serve you into the year 2000. My path to the practice of medicine and to this position is entwined with the physicians of Delaware and two of its past presidents. In 1959, I became a patient at the Alfred I. du Pont Institute and a patient of Dr. Dean MacEwen and Dr. Al Shands, two men who have done much for the orthopaedic care of children, not just in Delaware, but for the whole world. In them, I found physicians who cared for the whole patient and the child's family, and two men who saw the need to work with other physicians for the good of medicine and those in their care. When I started college, I was not thinking of medicine. My parents and I were convinced that physically

I would not be able to handle a career in medicine, having had polio at age three.

It was at a routine visit with Dr. MacEwen that he asked, "What do you want to do with your life?" I replied, "I guess I want to be a teacher." He immediately came back with, "You guess? Don't you know?" From that point we talked about my desire to be a physician and my family's concerns. Dean offered me a position as a research student at the Institute. He thought if I could keep up with the residents, as well as work in the research lab, I would be able to handle medicine. I spent the next two summers becoming an expert in the experimental production of scoliosis in rabbits and keeping the hours of an orthopaedic resident. Determined that I could in fact make it as a doctor, I applied to the University of Virginia. Dr. Shands, a distinguished alumnus of the University of Virginia and past president of the Medical Society of Delaware, wrote a letter of introduction to the

Michael A. Alexander, M.D., practices pediatric physical medicine and rehabilitation at Al du Pont Hospital for Children in Wilmington, Delaware. He is the president of the Medical Society of Delaware.

dean of students on my behalf, and I was on my way. A few years later, contemplating a residency, I spoke with Dr. MacEwen on the realities of a career in orthopaedic surgery. Dean wisely pointed out that forty years of such demands might be hard to tolerate. Dean, based on having worked with another former president of this Society, Dr. Cucuzzella, suggested physical medicine and rehabilitation. It was my decision to go for boards in pediatrics. Eventually, I became the first pediatric physiatrist in the state of Delaware at the very hospital where I had been treated as a teenager. It is with great satisfaction and a measure of humility that I follow in the footsteps of such dedicated physicians.

The Medical Society of Delaware is the most unique organization I have ever had the privilege to be involved with. Never have I seen so many past presidents continue to serve within an organization. The combined wisdom and enthusiasm at any meeting of the Society is truly formidable.

Several years ago in an airport bookstore in Houston, I came across a book which, in an era of the Five-Minute Manager and other short cut treatises on management, has served me well. As I embark on my presidency, I shall endeavor to share its wisdom with you. The book is entitled, Don't Squat With Yer Spurs On: A Cowboy's Guide to Life by Texas Bix Bender.

For a small state we have much to say in the AMA. This is, in large part, due to our unified membership. We pay less for our combined membership than physicians in many, if not most, metropolitan areas pay for just their state and county memberships. Our combined membership allows our tiny state to send four delegates and four alternate delegates to the AMA meetings. "There's a lot more to ridin' a horse than just sittin' in the saddle and lettin' your feet hang down." Stephen Permut, a past president, spoke up as a delegate at the national meeting and was soon recognized as someone to listen to. He is now a member of the AMA

Council on Legislation and Vice-Chair of the E & M Coding Task Force. Yes, I know that the AMA has been accused of shooting itself in the foot. "Remain independent of any source of income that will deprive you of your personal liberties." Many of us were disappointed by the Sunbeam contract, but the AMA responded to the membership sentiment that the plan to affiliate with a company like Sunbeam was wrong. The housecleaning of top personnel that followed has resulted in a more responsive and leaner national organization. The AMA has rethought its philosophy and has moved forward. Commercial ventures that leave physicians open to criticism about putting the selling of products ahead of their patients must be avoided. "Good judgement comes from experience and a lot of that comes from bad judgement."

This year we will follow with interest the Physicians for Responsible Negotiating (PRN) as one of our own physicians, Dr. Michael Katz, will serve at the national leadership level on the governing board. "Never ask a barber if you need a haircut." Rather than leaving the physicians to turn to some existing union which has no expertise or insight into the practice of medicine and its ethics, the AMA has created a mechanism for physicians to come together, speaking in a collective voice, to meet the needs of their patients.

The truth is that when we need help with legislative issues, the AMA is there. As we face the insurance industry telling us to participate under their "all products" clause, the AMA is leading the charge. They have stood up to Goliath and Jack's Giant planned merger (Aetna-Prudential). By combining resources through the AMA, physicians can afford a slingshot.

"Never try to run a bluff when your poke's empty." As a small state, there is no way we can contest Medicare payment formulas, E & M coding and the countless intrusions of government and the insurance industry into our caring for our patients. But collectively, with our peers across the nation, our poke is full.

This year the Society will tackle state legislation to continue progress towards guaranteeing Delaware citizens a "Patient's Bill of Rights." We will have to work with different groups and people, some who in the past have even been at odds with us. The Society will need to work with other health providers, hospitals and even lawyers. To this, Tex would say, "Trust everyone in the game but cut the cards." We are the logical ones to cut the cards if we stay united on what is best for the patients and what will maintain quality medicine. We can prevail.

"Talk low, talk slow, and don't say too much." I have great hopes that as a Society alone and in concert with others, we will move into the computer age. Minutes and reports will be available to trustees and members on the Internet. With our respective specialty societies and the AMA, we will develop websites where our patients can access peer-reviewed reports, rather than sites which exist to sell products. It is a grave risk that the high technology options of the Internet allow society to regress to the era of snake oil testimonials, rather than evidence-based science. A few weeks ago I participated in a retreat of the Delaware Academy of Medicine in which they stressed their interest in moving teleconferencing and medicine forward to all the counties in Delaware. They will need our help if the content is to be something we all can agree should be available to the public.

No organization makes every call correctly. Representing the needs of different medical spe-

cialties and practice settings is a formidable and constantly shifting target. We share a common interest in humanity, which comes to us from Hippocrates, Maimonides and many great physicians over the ages. We will stumble and even make bad calls but always, hopefully, with the right goal in mind. "Makin' it in life is kinda like bustin' broncs: you're gonna get thrown a lot. This simple secret is to keep getting' back on."

"Tellin' a man to go to hell and makin' him do it are two entirely different propositions." The Medical Society of Delaware is your Society and if you are involved you have much to say about how and where it and the AMA will meet your needs. "Never take to sawin' on the branch that's supportin' you, unless you're bein' hung from it." Standing on the sidelines and taking pot shots at what is your only effective support system is a surefire way to find yourself hurtling towards the ground, alone. Join us as we move into the next millennium and make the Medical Society of Delaware work for all of us.

But please, if nothing else sticks in your memory from this address, remember squatting with your spurs on could be harmful to your health.



Michael A. Alexander, M.D.
President

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Evolution of a Disease

Robison D. Harley, M.D., Ph.D., F.A.C.S.

Dr. Harley has participated in many medical missions over the years. The following is a listing which exemplifies his tremendous contribution:

1) With **Project Hope** (Ship Hope) in Ceylon-Sri Lanka, Jamaica, Tunisia, Natal and Macao, Brazil ... Appointed Chief of Ophthalmology for Project Hope 2) **Care - Medico** in Algeria, Java, Bali, Malaysia 3) **International Society of Surgeons** - Kenya 4) **Project Orbis** in Ivory Coast (Cote D'Ivoire), West Africa - Djerba, Tunisia 5) **Temple University Eye Team** in Bangkok, Thailand - China: Jinan, Xian, Canton, Beijing, Hong Kong 6) **Medical Volunteer** in Pago Pago, Samoa - Cairo, Egypt - Panama and Canal Zone - Brazil: Reibero Preto, Rio DeJaneiro, San Paulo - St. Lucia, West Indies - Cape Town, South Africa - Bombay, India - Kathmandu, Nepal 7) **Volunteer for Family Practice** Westside Clinic (Adams St) Wilmington, DE - Claymont Health Services, Claymont, DE

INTRODUCTION

My introduction to a disease now recognized as Onchocerciasis occurred in Guatemala in early 1942 as the PanAmerican Highway was being rushed to completion.

A rumor circulating among the construction crew was that many villages through which the projected road would transverse contained hundreds of natives who were losing their sight to a disease endemic to the area. The road builders refused to proceed and sent word to Washington to that effect.

The completion of the new highway was essential for the delivery of food and war supplies to

the vital Panama Canal area, since German subs lying just outside the canal were sinking ships without opposition.

Washington contacted the General of the Army Medical Corp in Panama; I received orders to proceed at once by Army Air Corp plane to Guatemala City and submit a report on my investigation of the problem.

Upon arrival, I contacted the leading ophthalmologist, who had limited knowledge of a parasitic disease which was especially prevalent among the coffee plantation workers living in the higher altitudes. In Southern Mexico and Guatemala a related form of this condition was known locally as l'erysiele du littoral (Coast Erysipelas), which may lead to blindness. The life cycle of this parasite was unknown, but transmission through the bite of a black fly was suspected.

Robison D. Harley, M.D., is a retired ophthalmologist residing in Wilmington, Delaware.

From Guatemala City, my guide and I journeyed the next day by car and burro to the plantation owner's home which was to be our headquarters.

The visiting tropical disease biologist, who was also present, focused his attention on a tiny black fly which seemed to be everywhere and especially biting the bare backs of coffee pickers. This black fly belonged to the genus, *Simulium damnosum*. The other obvious observation was the large walnut-sized nodules occurring over the bony prominences of the body, namely hips, scalp and ribs of the workers. Under local anesthesia, a dissection of these masses disclosed tightly coiled worms. The smaller worm measured two to three cm in length while the larger, presumably female, worm measured 30 to 60 cm.

Visual problems were common, ranging from red, painful eyes with punctate white spots in the cornea to severe opacification.

Meanwhile highway construction resumed but avoided the endemic higher altitude zones where the disease was so prominent.

Forty-five years later, on a volunteer mission in West Africa with Project Orbis, this parasitic disease was encountered again at lower altitudes in the Ivory Coast and Mali.

There was much more to be learned about this parasitic disease which causes so much human suffering in an estimated 20 to 30 million people. In West Africa and the Congo, it is reported that 45 percent of subjects examined exhibited evidence of this microfilarial infestation.

The World Health Organization has now undertaken an extensive control program in West Africa and the disease is now much better understood.

ONCHOCERCIASIS

Onchocerciasis or "river blindness" is a filarial disease caused by the nematode, *Onchocerca*

Volvulus. This parasitic worm is viviparous and for most of its ten-year life, the female discharges countless embryos of microfilaria into the dermal tissue where they cause intense itching, irritation and skin lesions. In addition the microfilaria often invade the eye provoking varying degrees of severe inflammatory eye disorders.

These microfilaria from a human host are ingested during the bite of a fly of the genus *Simulium damnosum*. They undergo morphological changes as they transform into infective larvae and find their way to the insect's mouth parts. During a subsequent bite they are injected into another human host. These changes within the insect vector are essential for the continued spread of Onchocerciasis.

The distribution of the disease is solely dependent on the fly vector which has a distinct aquatic stage in rapidly moving streams. Since the disease is especially prevalent along waterways, it has acquired the name of "river blindness."

Only the female fly bites humans, since blood is needed for the maturation of the batch of eggs produced. The eggs have a sticky exterior and attach to small twigs and plant stems in the river stream. The eggs hatch into larvae and then to pupa and in four to five days become a winged adult *Simulium damnosum* fly.

While this highly specialized tropical disease occurs along coastal Central America and the upper part of South America, it is especially rife in West Africa, Ivory Coast, Ghana, Togo, Benin, Burkina Faso and Mali.

OCULAR CHANGES

Visual loss creates the greatest medical and socioeconomic problem. The offspring of the adult worms are tiny motile, microfilaria which migrate in the subcutaneous tissue and can be found throughout the eye in the cornea, iris, vitreous and frequently can be identified swimming in the aqueous humor by slit lamp microscopy.

In recently infected patients, the microfilaria do not appear to cause much inflammatory response, but in long-standing cases the dead microfilaria cause localized corneal stromal response which eventuates in opacification of the cornea. The increased numbers of tiny worms results in an anterior uveitis with pupillary displacement and synechia with secondary lens changes. Chorio-retinal scarring with atrophic macular changes along with optic nerve swelling may be observed before the cornea becomes completely opacified.

SKIN CHANGES

Aside from the ocular complications, Onchocerciasis has a severe impact on the skin. The chronic dermatitis gives rise to intolerable itching and hyperpigmentation as well as areas of depigmentation. In some individuals, as a result of scarring or obstruction of the lymphatics, there may occur enlarged inguinal nodes and distorted pendulous changes especially in the male genitalia. Elephantiasitic changes have been reported. Diagnosis can be made on the basis of exposure and identification of microfilaria in skin biopsies.

THERAPY

Two drugs — Diethylcarbamazine (DEC) and Suramin — have been used for the treatment of

Onchocerciasis. DEC is effective as a microfilaricide but has limited effect on the adult worm. The major complication is that large numbers of microfilarial deaths cause an inflammatory response in the eye with increased visual loss and heightened dermatitis. Modifying the drug dosage reduces its effectiveness.

Suramin causes death of the adult worm and microfilaria but likewise results in a severe systemic response.

More recently, another microfilaricidal drug called Ivermectin (Mectizan by Merck) was approved for treatment in 1987. Merck announced at that time it would supply the drug free of charge. It is effective in the disappearance of microfilaria slowly over a period of three months. Although the treatment does not eradicate all microfilaria, the inflammatory response of the treated individual is much less and it is hopeful that repeated doses will be effective.

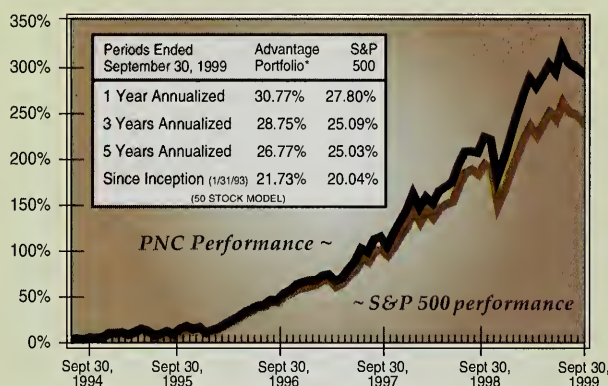
Vector control is effective but requires spraying over large areas and is far more labor intensive. Excision of large nodules containing the adult male and female worms is only partially successful in controlling the disease and is unlikely to eradicate Onchocerciasis.

John F. Gehret, M.D., F.A.C.O.G.

*Announces his retirement from the practice
of gynecology effective December 31, 1999.*

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Aid for International Medicine, Inc. (AIM) Our Last Ten Years

John M. Levinson, M.D., F.A.C.O.G., President & Founder

AIM has been active for 35 years, sending hundreds of health professionals overseas for volunteer work and giving over \$8,000,000 of aid to developing countries in need as well as at home. The organization was founded by John M. Levinson, M.D., following his first medical teaching visits to South Vietnam in 1963 and 1964.

In 1989, an article appeared in the *Delaware Medical Journal* which detailed the first 25 years of AIM. This article picks up where we left off; discussing AIM's past ten years.

AIM is an independent, non-profit, philanthropic organization that was founded in 1965. AIM's purpose is to advance medical aid and medical

education in areas worldwide where members of AIM's Board have personally served and documented a need. Our tax-exempt organization, under its broad charter, has allowed Delaware health professionals and their colleagues to do volunteer work, both here and abroad. All Board members and administrative staff work without compensation, and all physicians' programs are self-funded.

As we have become better known, not only in Delaware but in surrounding states, many donations of excellent medical equipment, surgical supplies and up-to-date medical products have been made. Almost invariably we have found a home for these donations.

It is not our style to solicit financial contributions, something done only on one special occasion as detailed later in this report. However, many voluntary contributions have come from friends, patients and Board members.

Dr. Levinson practiced medicine in Wilmington, Delaware, for over 30 years. He is past president of the Explorers Club in New York City, and has frequently testified before the U.S. Senate on medicine in Southeast Asia. Recently he published a book on Polar Medicine. He is an Honorary Professor of Obstetrics & Gynecology at Jefferson Medical College of Thomas Jefferson University.

It is not the intent of this article to detail all our work over these additional ten years. The reader may wonder why we have so many small projects. The answer is simple. The needs were not being met by larger organizations, and working on a direct person-to-person basis, it is not only more productive and more fun, but it is amazing how cost effective we can be. A little help often goes a long, long way.

One of the most frequently asked questions is: "What have you done here at home?"

Well, almost \$100,000 has been given for scholarships for the funds established for the late William P. Frank of the *News Journal*, our Board member and friend; for the Navajo National Health Foundation; and to Jefferson Medical College. The Claymont Community Center and the Westside Health Clinic received about \$20,000 of medical equipment and many of our Board members donate time and effort at these locations. Planned Parenthood of Delaware was given a computer and supplies, and the Volunteers for Adolescent Pregnancy Prevention was given a grant toward their excellent work.

Clinical clerkships were arranged for American medical students in Thailand and Jamaica. Regrettably, in spite of on-site assistance and a tremendous effort on our part, we found the students did not fulfill their obligations and these clerkships were discontinued.

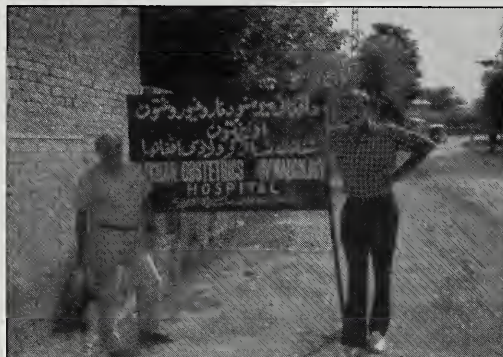
The College of Nursing at the University of Delaware received over \$40,000 worth of outdated medical supplies and equipment to use for teaching purposes. Funds were given to such diverse groups as immigrant Russian Jews for medical prescriptions; the Kalmar Nyckel Foundation was funded to teach underprivileged inner-city

youth carpentry skills; and Rotary International was again given funds for its program to eradicate poliomyelitis worldwide. The Delaware Museum of Natural History received a teaching grant, and the Delaware Academy of Medicine was funded to initiate a Historical Committee.

In addition, the Academy was given historical books and antique medical instruments. We gave Interchurch Medical Assistance of Maryland many thou-

sands of dollars in supplies that we were unable to place.

Through special arrangements with the U.S. Department of Defense, wounded from the Afghan war were brought to Delaware. Orthopaedic surgery and eye surgery were done by Delaware physicians who donated their time and expertise, and Delaware hospitals provided service gratis. This took some special effort on our part and only several hundred dollars for medications after hospital discharge ... could we say: "Not bad for a small town!"



Thomas S. Durant, M.D., of Boston, Massachusetts, with the author where they established the first OB-GYN surgical unit for the Afghan Freedom Fighters.



Thomas S. Durant, M.D., on teaching rounds with Afghan doctors.

In 1990, an eight-year effort culminated in bringing a Vietnamese family of six to Wilmington, Delaware. One child, suffering from an extremely severe post poliomyelitis syndrome, underwent multiple surgeries that have allowed her to become a functional person, receive an education and become employable. All

members of this family are employed and several have received college degrees. They are now U.S. citizens. We have given them no financial support for some years. They are truly a success story.

In 1992, we formed an Antarctic health and safety group to work with the National Science Foundation. In 1995, AIM held the first conference on health and safety for expeditions and tourists in the polar world at the Scott Polar Research Institute of the University of Cambridge in England. Forty explorers, physicians, and scientists from around the world attended the three-day meeting. This conference led to the publication of *SAFE PASSAGE QUESTIONED, Medical Care and Safety for the Polar Tourist*. This book was funded through AIM by the generosity of the late Jack D. Lange, M.D. This world-renowned medical publisher and former vice president, and later Chairman of our Advisory Board of Directors, is the Honorary Editor of our book. He is honored and recognized for donating over 350,000 medical texts through AIM to the developing world. All royalties from our book are being used for medical library programs to continue his work. AIM has made significant contributions to the Jack and DeLoris Special Collection Reading Room at the University of California College of Medicine at San Francisco, and additional contributions in his memory to the International Foundation for Eye Research, which he started. Why did this distinguished professor of medicine and renowned philanthropist join AIM in 1967? Very simply, he was a pragmatic man who insisted on getting things accomplished in a simple way. Our thinking blended and it worked!

In the Canadian Arctic we supported an expedition studying health systems on Baffin Island, as well as supporting three students involved in expedition "Ice Walk" to the North Pole.

The general hospital in Milot, Haiti, desperately needs teaching and service. One of our very dedicated Board members has made almost a dozen working visits, bringing with him about \$20,000 worth of surgical supplies. Our senior vice president has been involved in St. Lucia's medicine for over 30 years. In addition to consulting, he has brought with him several times a year, for over three decades, many thousands of dollars in medical and surgical supplies as well as books for the Anne Galet library that we all established there years ago. Various other

Delawareans have participated there, and more recently a Delaware nurse and surgeon worked at the Victoria Hospital in Castries.

In Honduras, a gynecologist, two general surgeons and an x-ray technician, all Delawareans, were sent to help rebuild the medical capability of the Contras from Nicaragua. As a side issue, AIM provided the funds to rebuild the kitchen of their major rehabilitation center. On this special effort our aid and expertise were solicited and financed by the U.S. Agency for International Development. On several occasions, we have sent needed medical supplies to charity groups in El Salvador.

Major opportunities have presented in Belize. Several years ago, two of our Board members accompanied a Massachusetts Rotary International group bringing over \$1,000,000 of medical equipment to that beautiful Central American country. We found screening for malaria was slowed by a lack of microscopes. Consequently, two of our Board members dusted off their medical school microscopes which are now in outlying hospitals diagnosing malaria daily. Due to the geographic proximity to the United States, it was reasonably easy for a colleague in Boston to arrange an excellent medical teaching program for Belize's physicians. That is in progress and another Delaware member of our Board recently lectured and performed surgery there, ably assisted by his wife. Through his enthusiasm, over \$250,000 of excellent medical equipment has been donated to AIM. Following our usual practice, he obtained donors to fund transportation for the equipment. Belize is now "his project." We look to him for decisions, funding and recruiting more physicians for Belize. He is already planning a return trip.

We haven't forgotten South America. In a cooperative project with the World Eye Foundation, we provided \$28,000 of intraocular lenses.

Moving eastward lies Africa with its never-ending needs. The Addis Ababa Fistula Hospital in Ethiopia is the only hospital in the world specifically dedicated to the cure of these devastating injuries of childbirth, i.e., bladder and

bowel fistulae. They have done over 20,000 operations on these women who constantly soil themselves with their bodily functions. The great majority have been successful, and these grateful women are again accepted by their families, may have normal babies and lead productive lives. One of our Board members made twelve learning and teaching visits with Dr. Reg and Dr. Catherine Hamlin. Today, Ethiopian gynecologists do most of the surgery, and they have trained many African gynecologists and others from around the world in these difficult techniques. Another AIM Board member visited the hospital last year and hopes to initiate the most advanced techniques for making artificial bladders for the most severe and hopeless cases.

For almost 30 years we have been sending funds to them, to build and run the hospital. In 1998 Dr. Catherine Hamlin visited us after receiving a \$100,000 peace prize from Rotary International. Although we as an organization had never previously asked for donations, we worked with the Rotary Club of Wilmington, Delaware, on a matching grant to help the Fistula Hospital become fully self-sustaining. Our goals were exceeded and we are proud to announce that we have sent over \$400,000 to the Fistula Trust over these many years. In addition, we have sent many supplies to this remarkable institution.

For hospitals in Somali we have sent supplies, and through the efforts of the vice president of the American Refugee Committee (ARC), who is also chairman of our Advisory Board, we have sent funds. This physician has served many times in Bosnia, Rwanda and Somali and personally administered funding for us.

The Good Shepherd Hospital in Swaziland had the good fortune of having one of our well-trained younger Delaware physicians and his

dedicated wife spend a month providing them with service and teaching. They brought with them over \$11,000 of medical supplies and returned with an extremely detailed report. We are looking for someone to fill their shoes.

The Frere Hospital in South Africa was the first benefactor of royalties from our book *Safe Passage Questioned*. To them, we sent over 700 tapes on all phases of up-to-date medical care for their new library.

In Liberia, the Phoebe Hospital was given over \$33,000 in medical supplies and an x-ray technician, physician and his wife, all from Delaware, provided service and teaching. It is most interesting that all of our medical personnel return from third world countries feeling that they have learned more than they have taught. Invariably, they gain an insight into another culture, and gain a real humility as they view their own problems.

In West Africa, a fire in the village of Fanvi in Benin destroyed many homes. Funds were provided for rebuilding.

In Nigeria, an old friend retired to do ophthalmology at the Kano Eye Hospital. He was given a camera to photograph

intraocular eye disorders for teaching purposes. The Living Word Mission Hospital, also in Nigeria, was given teaching and almost \$50,000 in medical supplies, books and hospital beds.

Our doctor, who became very skilled in fistula surgery in Ethiopia, went on to do and teach these techniques in Malawi for some weeks yearly for six years. As always, he carried an extra suitcase with sutures and other supplies that are often not available in poor hospitals in the developing world.

Many years ago, one of our Delaware surgeons and his wife worked at the Jane Furse Memorial



Cambodian gynecologist working at TRAT, the refugee camp that AIM supplied with a basic D&E kit.

Hospital in the Transval. In more recent times, another Delaware surgeon went to do service and teach, while his wife helped in a tuberculosis clinic and in the medical record department.

Medical lectures were delivered in Capetown, South Africa, by one of our Delaware Board physicians, and funds were again sent to the rural clinics in Zaire.

The Middle East has benefited by the visits of Delaware surgeons. Lectures have been given in Israel, over a dozen surgical teaching visits have been made to hospitals in Iran, Iraq and Jordan. Many tens of thousands of dollars of equipment were donated to the hospitals where they worked.

In Iran, a surgeon working through AIM brought \$1,600,000 in medical and surgical supplies to earthquake victims and Kurd refugees who had fled from Iraq. His three-month tour was much longer than most of our volunteers have been able to do.

The genesis of AIM was in Southeast Asia, and we have not forgotten our roots. Just this past year, two doctors from our Board, one from Delaware and one from Massachusetts, accompanied by their sons, returned to Cambodian refugee camps. One particularly well-run camp at the Burmese border had an excellent tuberculosis program which we helped fund. Another camp just inside of Thailand is literally surrounded on three sides by Cambodia and random gunfire is the rule nightly. Because of these dangers, the western refugee workers and health team were only permitted to stay in the camp from 8:00 a.m. to 4:00 p.m. daily. At this camp we found no instruments for doing a "D&E", i.e.,

a simple gynecologic procedure to terminate a miscarriage. A complete surgical kit was do-



The chief nurse in the OB-GYN operating room is an old friend. The author worked with her first in 1963, and last in 1989.

nated by a Thai gynecologist on our Board, and now a Cambodian gynecologist working in this camp can utilize her skills. Previously, hemorrhaging women were often brought in to the tiny hospital, and then transported by the Thais border police in a truck for 50 kilometers over horrible roads to a hospital that could do the necessary surgery. Blood was usually not avail-

able and death not uncommon.

The most common diagnosis in their 25-bed hospital is "Land Mine Injury" — often young children are severely wounded after straying only a few steps off the usual paths in the camps. Sadly enough, one of the AIM doctors on this trip was recently injured by a land mine in Kosovo.

Previously, we had funded the I.R.C. in their worldwide campaign against the deployment of land mines. Truly, this is a most important part of preventive medicine.

We took microsurgical instruments to the Cho Ray Hospital in Saigon, but our main effort there in recent years has been a chemotherapy project at the Tu Du Hospital - the obstetrical and gynecological division of the University of Saigon College of Medicine. Their incidence of gestational trophoblastic disease is the highest in the world, and was first documented by this author in 1963. New journals and books on treatment, and our \$100,000 of chemotherapy were "talked through" Vietnamese customs authorities, and we arranged for them to have a



Three survivors from choriocarcinoma. At the Tu Du Maternity Hospital, Saigon, the methotrexate for this disease was supplied by AIM.

relationship with the New England Trophoblastic Disease Center at Harvard Medical School.

Gestational trophoblastic disease, which begins in the pregnant uterus, has proved to be the first tumor that most frequently can be cured by chemotherapy, and as said in 1968 by Dr. Hertig, "God's first cancer, man's first cure."

To Taiwan went medical supplies, and Nepal received neurosurgical equipment, funds for Sir Edmund Hillary's foundation to assist in needs for clinical medicine and student scholarships. Funds were also sent to assist a clinic in India. A Delaware husband and wife, both plastic surgeons, lectured, did plastic surgery, and carried supplies to two hospitals in India. A Delaware ophthalmologist and his medical student son, spent a month in India and Nepal teaching, doing cataract surgery and used five corneas from the Delaware Eye Bank in their surgery.

In Indonesia, we provided the medical supplies, and a Delaware physician was the doctor for the "Great Jukung Race" - really an expedition of ten ancient type sailing vessels, each sailed by a crew from a different country. The serious medical problem of this expedition occurred when massive swarms of bees attacked the voyagers when they landed on an island off New Guinea. Our emergency supplies of adrenalin, antihistamines and cortisone saved several young crew members' lives that day. The six weeks' journey from the island of Bali to Darwin, Australia, may have been a "first," or a journey similar to that first done by the indigenous population thousands of years ago.

A major grant was given to the Royal Flying Doctor Service of Australia. Their intrepid pilots and physicians provide full medical service in the Outback, and many of the Aborigines rely on them for their total medical care.

Many of our projects truly began by accident. Several years ago, a casual conversation among several Delawareans led to sending a valuable ultrasound machine and other needed equip-

ment to Romania. How we latch on to free transportation through the U.S. Air Force, other agencies, et cetera, is another story itself!

Before 1991, we, as most agencies, had virtually no contact with the USSR. That rapidly changed as the former Soviet Union disintegrated and many little opportunities presented. We helped a Siberian boy go to the MD Anderson Hospital in Texas for treatment of a rare malignancy. We got medical supplies to a distant area of the Tundra, and we managed to have the U.S. Air Force from Dover, Delaware, fly medical supplies to the Ukraine!



The Russian icebreaker, the Sovetskiy Soyuz, at the North Pole. Many Delaware physicians have worked on her, helping Russian doctors and taking medical supplies to Siberia.

"Serendipity" is the only word to describe how we have helped areas of the former Soviet Union. From 1991-1995 this author became the medical director for a company that carried tourists to the Antarctic and high Arctic areas of the world by Russian diesel and nuclear powered icebreakers. Many of us from Delaware served as ship's surgeon on these vessels. Although we traded our medical services to pas-

sengers for fascinating trips, we not infrequently treated Russian crew who sought our aid. The Russian physicians assigned to the crews were helped whenever possible.

We carried medical supplies and textbooks to the Sovetskiy Soyuz, and utilized the helicopter from this great nuclear icebreaker to bring desperately needed medicines to an isolated Chuckchi village on Wrangel Island north of Siberia. When tourists visited Uelen on the far east coast of Siberia, they were fascinated by the intricate scrimshaw produced from walrus ivory but found the children had no art supplies, nor was there a medical clinic. On the next trip we left art supplies purchased through the generosity of the tourists, and the tour company matched AIM's money to provide basic medicines for the children of the village. At the end of the Arctic cruising season in 1991, a large supply of antibiotics with approaching date dead-

lines was given to the Animal Humane Society in St. Petersburg.

During the past 35 years, our network of friends who have made all of this possible has literally been worldwide. Table 1 lists Delawareans who furnished invaluable aid over these past ten years. Not all are health professionals, but all were vital, and should be equally recognized.

Even though we are a 501-(c)3 organization that offers state and federal tax exemptions, we have resisted all temptations to become a large organization. We boast in having the lowest percentage of administrative expenses of any agency that ever registered with the Advisory Committee on Voluntary Aid, U.S. Department of State. Over these many years we have been inundated with letters and phone calls that essentially say "What can you do for me"; that is not our style. We do what we can, when we can, in the simplest way possible.

Where do we go from here? I'm really not sure. Senator Edward M. Kennedy, who has supported our efforts for over 30 years, has advised the Ambassador from Vietnam that we are the premier American group to work with for medical programs. Belize offers us excellent challenges and opportunities. We welcome all Delawareans who wish to be involved. Our only goal

Table 1. AIM Volunteers 1989-1999

Ari Abel, Jr., M.D.	Pierre L. LeRoy, M.D.
Robert Abel, M.D.	Amir Mansoor, M.D.
Senator Joseph R. Biden, Jr.	Barbara Price Martin
Richard J. Both	G. Dean MacEwen, M.D.
Linda O. Bradford, R.T.	Molly McBride, M.D.
Governor Thomas Carper	Susan McBride, R.N.
Michelle Donalik, M.S., R.N., R.N.P.	Edgar R. Miller, Jr., M.D.
Robert F. Duffy, R.Ph.	Betty J. Paulanka, Ed.D., R.N.
Davis G. Durham, M.D.	Kathleen M. Puit
Irwin W. Fish, P.A.	James F. Reamer, M.D.
Maria Fitzpatrick, M.D.	Senator William V. Roth, Jr.
Errol Ger, M.D.	Colleen D. Ryder, R.Ph.
Ruth Ger	David E. Saunders, M.D.
Cecil C. Gordon, Jr., M.D.	Gregory S. Smith, M.D.
Sophia Grim	Matthew Sullivan, M.D.
Robison D. Harley, M.D., Ph.D.	Susan Sullivan, R.N.
Pierre duPont Hayward	Richard N. Taylor, M.D.
Peter S. Huang, M.D.	Virginia T. Taylor, R.N.
Elizabeth M. Jenkins, R.N., M.S.	Claudette Weiss, R.N.
Ali Kalamchi, M.D.	Richard H. Weiss, M.D.
Alan Levin	Diane Levin Widder
John M. Levinson, M.D.	Katy Woo

is good medicine given on a friendly basis. When you wish to contribute your time and expertise, medical and surgical supplies, please call us. Sorry, no E-mail. We're old-fashioned.

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Eye Problems in the Polar Regions

Davis G. Durham, M.D., F.A.C.S.

Dr. Durham has always had an urge to travel, even as a boy. During WWII, he saw service in General Hospitals as well as a Battalion Aid Surgeon in France and Germany for which he was awarded the European Theatre Ribbon with two battle stars, the Combat Medical Badge, and the Bronze Star. The experience also exposed him to ophthalmology and the beginning of his specialty training. In 1949, he seized the opportunity to join a group of ophthalmologists evaluating a condition known as "Snow Blindness" among the Eskimos of Alaska. This was the first of several investigational and teaching expeditions.

Extensive References Available Upon Request

The title is somewhat of a misnomer and perhaps should be titled "In the Arctic Regions." There are two kinds of humans in the Polar Regions:

- 1) Those indigenous to the area such as Eskimos, and
- 2) Those who travel there temporarily such as explorers or tourists, or for commercial interests.

In the Antarctic there are only the latter, and I know nothing of the eye problems of penguins!

The term "Snow Blindness" has been used for centuries but is a misnomer, and loss of vision in the arctic encompasses many different etiologies. Ophthalmology in the last 50 years has determined these causes as follows: 1) Phlyctenular keratitis, 2) Climatic Droplet Keratopathy, 3) Solar Keratitis, 4) Trachoma, 5) Trauma.

Davis G. Durham, M.D., is a practicing ophthalmologist in Wilmington, Delaware.

PHLYCTENULAR KERATITIS

In 1949, I was privileged to be part of a team of ophthalmologists that investigated the cause of blindness among the Alaskan Eskimos. It was well known and documented that there was much blindness within this population. It had been noted that none of the early explorers reported any evidence of eye disease. Up until 1949 there had been no effort to establish the etiology.

Dr. Milo Fritz, an ophthalmologist in Anchorage, and also an itinerant physician to remote areas of Alaska, organized this project. He enlisted Dr. Phillips Thygeson, Professor of Ophthalmology at the University of California and later Head of the Proctor Foundation, and recognized as one of the world authorities on external diseases of the eye. The site selected was a former WWII Naval Base at Sitka which had become a school for Eskimo children. The school consisted of 350 Eskimo children from all parts

of Alaska, thus facilitating a wide distribution of subjects in one location and providing a great savings in time of moving personnel, eye equipment, and laboratory facilities. With modern eye microscopes (slit lamps), it was clearly evident that the loss of vision was due to corneal scars induced by frequent attacks of phlyctenular keratoconjunctivitis.

The acute attack begins with phlyctenulae at the limbus of the cornea, spreading into the corneal stroma via blood vessels in an otherwise optically clear tissue. The end result is scarring. Each additional attack produces more scarring, eventually leading to reduced vision or even blindness.

Complete laboratory evaluations were made. Tests for syphilis were negative in every child. There was no evidence of staphylococci infection. No nutritional or vitamin deficiencies were noted. X-rays showed that all children with phlyctenular keratitis had evidence of systemic tuberculosis and that all of these children were sensitive to 1st strength tuberculin. Of 346 children, corneal scars were seen in 147 cases and active phlyctenular disease was seen in ten cases. Exams showed no evidence of epiblepharon as suggested by Mould in 1936 nor any cases of trichiasis or exposure keratitis. It was concluded by this evidence that the blindness was caused by a sensitivity and lack of immunity to the tubercle bacillus. However, no actual tubercle bacillus was found in the eye.

In Alaska (1965), 53 percent of school age children and 45 percent of adults had scarring, with the incidence being more common among women. Ninety-three percent of the children tested with opacities were tuberculin positive and only 34 percent of those without opacities were reactors. Therefore, TB is the major etiologic factor in phlyctenular keratitis conjunctivitis in Southwest Alaska. Treatment of TB with isoniazid showed less frequent extension and more regression of opacities as compared to those of a placebo. After discontinuing treatment, the incidence of opacities was identical to the placebo group.

The Eskimos, like the Polynesians, had little resistance to diseases brought by European explorers and settlers. Tuberculosis was rampant

and easily spread within the close living quarters of the Arctic people. The intense cold leads to overcrowding and imperfect sanitation.

Fortunately, about this time, steroids were discovered. We learned that overnight an acute attack of phlyctenulosis could be aborted by placing steroid drops in the conjunctival eye. Since the initial attack is always limbal in origin, it takes repeated episodes to damage the vision. Phlyctenulosis of non-tuberculosis origin is extremely rare or absent among the Eskimos.

Therefore, a regimen was instituted by having the public health nurse place local steroid drops for four days in the red eyes of any Eskimo child. This was done even before an etiologic diagnosis was made and has proven extremely successful. In almost 50 years of this therapy, the incidence of loss of vision from this cause has almost been eliminated.

CLIMATIC DROPLET KERATOPATHY

The second reported cause of "Snow Blindness" has been called "Climatic Droplet Keratopathy" or "Labrador Keratitis." Although all other parts of the body are covered with clothes to offer protection against the cold and sun, the eye is an exception which is, by necessity, always unprotected. Perhaps the Eskimos, with the round shape of the face and the narrow interpalpebral fissure, shelters effectively against the climate. The Eskimo has lived the longest in the arctic and thus has the longest history of genetic adaptation to arctic conditions.

Climatic droplet keratopathy is characterized by ribbonlike corneal scarring and is due to constant exposure to wind, wind blown ice, and sun. It is only seen in older males who have spent their entire lives outdoors. It usually does not extend to the pupillary area and thus does not effect visual acuity. It has been noted in Labrador, and therefore the name. The sun is stronger in Labrador than regions further north. It is frequently associated with pterygium formations with no evidence of secondary infection. It is concluded as being due to exposure to the elements.

It has been suggested that contact lenses might offer an excellent preventive. Two Caucasians wearing contact lenses with similar exposures showed no evidence of corneal damage.

SOLAR KERATITIS

The third cause of "Snow Blindness" is Solar Keratitis and is due to ultraviolet light on the cornea. The onset is usually within 12 hours of exposure and consists of inflamed conjunctiva, tearing, severe pain and photophobia so severe as to be visually disabling. The condition is equivalent to "welders flash." The treatment consists of rest, steroid drops, and pain relievers. This condition clears within two to three days with no permanent visual loss.

Pterygium and Pingeculas are common with continued exposure to ultraviolet light but are not visually disabling. Solar Keratitis is frequently experienced by explorers. Hemmingsen and Douglas determined a threshold energy for corneal damage by UV radiation. They found that, when compared to humans, penguins have over two times the resistance to UV radiation and dogs have three times the natural protection.

Amundson had goggles patterned like the Eskimos but with the addition of photographic film as a filter. Dr. Frederick Cook developed an amber colored glass from his photographic plates which gave relief from the glare of light without restricting the field of vision. I might add here that the lens of the human eye acts as a UV filter so the retina is not damaged by UV light. It is worth noting that patients who have had their cataracts removed no longer possess this protection and need to be aware of this and to use extra precaution against UV exposure. Some newer IOL implants do provide UV protection.

TRACHOMA, TRAUMA & MORE

Trachoma has been reported in the Russian literature as causing blindness in Siberia. This is an infection common in the Mediterranean

area that is thought to have been transmitted by the early traders to Siberia. It is not present in Eskimos. It is treatable by local sulfa or antibiotic drops.

Trauma has become an increasing cause of loss of vision due to snowmobiles, drunken brawls, and construction work. The treatment is prevention by wearing eye protection and helmets, and by education.

The Eskimo is also subject to acute glaucoma, which the Native American is not. This is due to an anatomical narrow anterior chamber characteristic of this race and is of congenital origin.

Life expectancy will influence the presence of the degenerative diseases such as cataracts and macular degeneration — both rare in primitive societies. Average life expectancy of the Eskimo at birth is 34.5 years.

Interestingly, myopia has been increasing in the Eskimo population. Formerly this was only present in those of mixed Eskimo/Caucasian race. Nearsightedness has almost never existed in cultures such as the Polynesians, Native Americans, and African Americans. Perhaps reflecting survival of the fittest? It is also been noted recently in Greenland, the Soviet north and Labrador.

CONCLUSIONS

In the Arctic regions the effect of cold is all important in determining life-style, but the history of contacts with other races may help to decide the type of infectious diseases found. The Eskimo was exposed to tuberculosis with little resistance and its spread was fostered by their way of life dictated by the elements.

"Snow blindness" is not an adequate explanation for loss of vision in the polar regions. There is always an etiologic or pathologic reason. Once the diagnosis is established, treatment and prevention are available.

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Medical Mission to Honduras December 20, 1998 - January 2, 1999

Robert W. Frelick, M.D.

BACKGROUND

In the middle of December 1998 I responded to an appeal for physicians (from Church World Services) for emergency medical relief teams to Honduras. Following the massive destruction caused in October by Hurricane Mitch, there was a need to prevent outbreaks of illness by providing primary care to at-risk populations. After reviewing the types of illnesses being encountered and the medications being used for treatment, I offered to go even though I did not speak Spanish. The organizers had a hard time getting me to Honduras during the Christmas holidays. Luggage was burdened with camping supplies such as a collapsible bed, boots, rain gear, filter and pump for water, clothes, and several hundred dollars worth of medications provided at cost by Christiana Hospital and paid

for by Westminster Church in Wilmington. I also took two books (on infectious diseases and dermatology) with an incorrect assumption that something like a Merck's Manual would be available in Honduras.

On December 20th our team (Table 1), arriving on several different airlines, was met in Tegucigalpa, the capital of Honduras, by the Honduran Christian Commission for Development (CCD). The CCD has functioned for over 15 years in 114 Honduran villages and was the local organizing and support group for the project.

CCD provided the team with a 12-passenger van to and from their retreat headquarters at Mount Carmel, just outside of the capital, and their regional center in the state of Santa Barbara in the northwestern part of Honduras near the Guatemalan border. This was an area which had been hit especially hard by Mitch. As we

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proceeded onward to the clinics, some areas were rough and bumpy where Mitch produced mud slides destroying sections of road. The rural roads to the clinic areas were narrow and usually rutted. Due to poor road conditions, on our return trip to the regional headquarters, we were stopped by an accident that had occurred a few minutes earlier. An officer had been thrown through the windshield of an overturned police truck. We tended to the officer and two other injured policemen. It is not often that an accident such as this can be served by a physician and nurse for each patient, plus a truck full of medical supplies.

We had to ford various types of streams where the bridges had been destroyed by Mitch. Much of the corn crop had been lost and many of the banana and pineapple crops were damaged. However, sugar cane may have been helped by the high waters. The mosquito population was down, probably thanks to Mitch's raging flood waters, which subsequently subsided probably destroying larvae. In some places we were bothered by very small flies, but houseflies were uncommon. Debris, largely downed trees and bushes, was strewn about eight to twelve feet above many current stream levels. The floods were produced by the equivalent of four and a half years of rain in nine days.

CLINIC FACILITIES, LIVING QUARTERS, AND LOGISTICS

The first clinic was in one room of a two-room school building built in 1998. It had no electricity or running water. Desks were piled on top of each other to form shelves for the medications and supplies. Patients were seen at one of the three desks served by two physicians and a nurse clinician. The second room became our sleeping quarters. With the aid of a faltering gasoline lantern the bedding was usually in place by 7:30. There was nothing much else to do in the dark except go to bed. Because of my

reputation for snoring, I gave the nurses permission to wake me if I was too noisy — They did. In the second village a number of cinder

block houses (probably built through CCD) had successfully withstood two feet of water from Mitch, unlike some other homes made of mud. Most homes had roofs of corrugated iron, but some still were thatched. There still was no electricity or running water. As in the first clinic, medications were

put on makeshift shelves and a window was used for dispensing drugs for patients waiting outside. The clinic was in a one-room school about 600 yards from the sleeping quarters in the one-room home of an owner who was said to be in a hospital. It had an outside latrine dated 1998 without a door. (Later, a drape was hung in front providing some privacy.) A barrel next to the latrine provided the water for "flushing."

The third village was in the Pines in northern Honduras close to the Guatemalan border. It was used instead of the original choice of a village church because it had running water from a cistern and a recently built public health clinic which was not being used. The waiting room became both a clinic and sleeping quarters. A sink to wash hands soon developed a leak and became useless, but wipes were available. The building had two six-inch fluorescent lights, powered by a Ford battery, which were used for a couple of hours each evening. One was on the porch and the other in our exam room (not in the sleeping area). A poorly used community center across from the clinic was furnished with two old pool tables and became the kitchen and dining area.

It was a challenge to keep clean, and because of intermittent rains it was hard to have dry, clean clothes. When the sun came out, the running water in the third village (from a cistern) in the rear of the building and a washboard became a laundry. It was easy to lose track of specific days. A nearby river, used for swimming by most of the nurses, had a welcome flow of warm

Table 1. Medical Mission Personnel

2	Physicians
1	Nurse Clinician
1	Clergyman
4	Nurses (1 was from the CCD)
1	Translator/Support Person
1	Cook
TOTAL: 10 PERSONS	

sulphur water from a spring up the hill from the river. A long concrete bridge which once had crossed the river had collapsed in the flood waters, but two suspension foot bridges were left. One was at quite an angle. The other was used to visit a newborn (one day old) on the other side.

CLINIC OPERATIONS

The CCD nurse wrote each patient's main problem on a small slip of paper to be presented to a villager who kept the lines of people from entering the clinic area until they were ready to be seen. After obtaining more history and examining the patients, the clinicians wrote their prescriptions on the triage slips of paper. Our efforts to tell patients how to use the medications were reinforced by the substitute pharmacists. Fortunately, my several translators were very helpful.

The triage nurse only allowed three of the sickest members of a family to be seen at the first two villages, and cut that to one in the last village. In the second village, because of rain and no room in the clinic, she set up her triage under an umbrella. Umbrellas were also used by the villagers as protection from the heat of the sun. Clinic operations usually came to a halt by 5:15 P.M. because of darkness, although sunset gained a minute or two each day. Over 100 patients were seen in an average day, so the total must have been over 500.

ILLNESSES

Many children had respiratory diseases, especially bronchitis, with very few sore throats and ear infections. A few had otitis externa, and there was some sinusitis. Many needed worm medications, either metronidazole (Flagyl), or mebendazole. There was evidence of malnutrition, especially among the youngest, and anemia. Dermatitis, chiefly impetigo, was common, but one woman with a black round rash seven to ten mm in diameter scattered over her arms and trunk stumped us. One pregnant woman had a breach presentation. We shared

some iodized salt from our food supply with a woman who had a very large goiter, and suggested more treatment in San Pedro Sulo. It was surprising to find some hypertensive patients and one with congestive failure. The patients, especially the youngest and the pregnant women, were given vitamins with folic acid. Iron was also freely dispensed as were many antibiotics for bronchial and urinary infections. Many, especially men, complained of high lumbar back aches which may have been related to the way they used their machetes, but very few had lower back pain. We had one machete laceration to suture.

Tension-type headaches were common with shoulder aches, probably related to how burdens were carried on the back of necks and shoulders. Some headaches also seemed related to eye strain. Almost no one wore glasses. Many of the older population had cataracts. Some had asthma, probably related to smoke exposure from their kitchens, which were in lean-tos attached to houses. It was handy to have broncho-dilators and inhalers for the asthmatics. A screened area with a place to examine adults lying down was especially useful for pregnant women. Vaginal infections were relatively common. In the absence of a speculum, bimanual pelvic exams (without stirrups) were done when required. We saw several women with gall bladder problems, but did not detect any hepatitis. A 10-year-old paraplegic girl, who had had prior surgery for spina bifida, presented with severe kypho-scoliosis and bronchopneumonia. (She might have been a candidate for the Alfred I. duPont Hospital in Wilmington if it was accepting patients out of the States without the ability to pay.) Another patient, who had a bad fall a month earlier, had absent breath sounds and flat percussion note over the right lower chest. She also had a bad cough which had preceded her fall. The CCD nurse was to arrange for her to get a chest x-ray and follow-up in San Pedro. A young man who probably had pulmonary tuberculosis had already been scheduled for further work-up. Diarrhea and gastritis with heartburn were common. One patient, who had been given a lot of different medications in the city a day earlier, came in with severe nausea and vomiting probably due to an ergot preparation used for mi-

graine. She also acted very depressed. Only a few seemed to be suffering from anxiety or depression secondary to Mitch. One young woman appeared to have a malignancy(? thyroid) with hard nodes in the supraclavicular area. The CCD nurse agreed to arrange for her to go to San Pedro. Another 25-year-old woman, who had delivered four months earlier and had been nursing, had a large open non-tender mass in her breast which the nurses tried to clean. It would be unusual for mastitis to look that bad. It felt more like cancer, in spite of her age. The nurses felt at home cleaning up some horrible looking dermatitis in feet and legs plus several large varicose ulcers on one patient. The advice to keep her legs elevated and clean would be hard to follow. A number of young women were not nursing "because their babies did not like the breast." Those babies tended to have diarrhea which probably was related to poorly prepared formulas and bottles. It was not clear that advice to use more care in preparing nursing bottles and formulas could or would be followed.

CONCLUSIONS BY THE TEAM

Our orientation from the World Council New York office had been helpful. It was surprising that more patients were not seen with injuries or diseases directly ascribed to Mitch, but in any case many were in need of medical help. One could question the long term effectiveness of the "band-aid" type of services provided without village health workers to prepare the villagers and to establish a follow-up health program. I wondered if successful development would be possible in a population made just healthy enough to produce more and more babies. Could electricity and a television for each house be one of the best ways to reduce the birth rate? (The use of hormones such as birth control pills to help regularize periods was feared by most women because of their birth control potentials.) In general, the villagers appeared to be happy. They showed an unusual degree of support for each other, especially the children. Most of the communities appeared to have little evidence of local leadership or initiative to improve their surroundings although we had little opportunity to survey their activities

It was most satisfying to see how well the team functioned in spite of changing personnel who had had no previous experience working together. Such success was probably related to the emergency situation and to the fact that our team was composed largely of medical professionals who were also people of "faith." It was obvious that all members of our team profited from the Honduran experience.

SUMMARY

This is the story of a team of medical professionals who responded to an appeal from Church World Services in New York to provide two weeks of primary care for Honduran people in areas devastated by Hurricane Mitch. It was a remarkable experience to see how a small team of changing physicians, nurses, and support personnel could function effectively although they had not known each other, or ever worked together before. Over a period of two weeks with two major holiday weekends and an unusual amount of time spent in travel, the team in seven working days provided primary care to about 500 patients ages 1 day to 82 years with limited medical supplies and no laboratory resources. The patients resided in rural villages, without electricity or running water, which could only be reached over poor rural roads. Full credit should be given to the Honduran CCD which provided support services for the dedicated, compassionate American volunteers, and to the Honduran villagers who patiently waited, often in the rain, to be seen. It is hoped that the medical services were as helpful to the recipients as the experience was to the team participants.

There is little doubt that long run efforts of CCD and other non-governmental organizations (NGOs) are needed to stimulate overall improvement in the standard of living in rural villages. Future sustained development will take local leadership to stimulate interest in a better future by spacing children so they can have improved education and healthier living conditions.

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Medical Assistance to the Dominican Republic By Health Professionals of the Delaware Army National Guard

Col. H. Theodore Harcke, MC DEARNG, M.D.

The opinions and assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Delaware Army National Guard or the U.S. Departments of the Army or Defense.

The United States military is involved in Humanitarian Assistance (HA) missions throughout the world. This often unrecognized activity of the uniformed services falls under the category of *Military Operations Other Than War (MOOTW)*.¹ Peace enforcement and peacekeeping operations like Bosnia and Kosovo along with humanitarian assistance operations like Somalia are at the highly visible end of the MOOTW spectrum. Quieter and less recognized assistance missions, however, occur regularly over the years with little public attention.

Central America, the Caribbean, and South America constitute the operational area of the

United States Southern Command (USSOUTHCOM). For over a decade, medical personnel have been brought into this theater to perform short duration missions (15 days) that provide health care to the people in underserved regions. As a result of recent Hurricanes George and Mitch, several countries experienced particularly devastating damage that destroyed infrastructure and acutely impacted on the short- and long-term health needs of their populations. (Honduras, Nicaragua, Dominican Republic). In response to these needs, USSOUTHCOM greatly accelerated its humanitarian assistance programs in 1999.

The down-sized active duty army medical force does not have the capability and resources to undertake all the humanitarian assistance missions, so the medical elements of the Army Reserve Components (Reserve and National Guard) are called upon. Joint Task Force "Caribbean-Castle 99" was organized by the Ala-

Dr. Harcke is the State Surgeon and Commander 59th Medical Detachment, Delaware Army National Guard. He works at the Alfred I. duPont Hospital for Children and is Professor of Radiology and Pediatrics at Jefferson Medical College and Clinical Professor of Radiology and Nuclear Medicine at the Uniformed Services University of the Health Sciences, Bethesda, Maryland.

bama Army National Guard under USSOUTHCOM directive. The task force mission was to conduct a six-month humanitarian assistance program in the interior of the Dominican Republic, where the effects of the hurricanes had been most severe and population less able to recover. One element of the task force would be engineers who would build schools; a second element would be medical. Medical teams of military health care personnel would work with host nation health care providers in primary care settings.

The Delaware Army National Guard provided a 33-person medical team of volunteers who conducted the first of the task force's three, two-week medical missions. The team was composed of physicians, physician assistants, dentists, nurses, other health care specialists, and administrative personnel (Table 1). The team included six bilingual Delaware Guard soldiers who served a vital role as interpreters. In-country Dominican military doctors and dentists joined the team. The task force engineers provided basic living (tents), food (army rations), potable water, and vehicles to the medical elements. The Army pre-shipped field medical and dental sets and bulk pharmaceuticals for the teams to the task force base camp.

Prior to the arrival of the medical teams, the Dominican Ministry of Health, the United

States Embassy, and Army representatives studied the area and selected sites for the teams.

Medical, dental, and veterinary services are considered, depending upon needs of the country and composition of a team.

Upon arrival in the country, the two key tasks are liaison with the site medical director to plan clinic operation and the preparation of pharmaceuticals. The team's bulk allocation of drugs must be broken down into ten equal allotments (one for each day of clinic operation). This ensures there will be no shortage or overage at the end of the operation. The team is self-sufficient, asking

for no host nation supplies or drugs. Each day's allocation is further broken down into individual amounts (e.g. one-month supply of multivitamins, a two-week supply of analgesic). All team members pitch in for this work. Only antibiotics are prepared on-site in a temporary

pharmacy. This is to facilitate rapid distribution to a large volume of patients. Obviously, the formulary is limited; it contains primarily analgesics, antibiotics, antiparasitics, and multivitamins.

During the first week of operations, Delaware's medical/dental team was assigned to work for five days in the out-patient clinic of

Sabana Grande de Boya Municipal Hospital (Figure 1). The hospital was about 90 minutes

Table 1. Delaware Army National Guard Medical/Dental Team

<u>OFFICER PERSONNEL</u>	
1	Administrative Officer
5	Physicians
1	Physician Assistant
2	Dentists
1	Pharmacy Officer
4	Nurses
1	Patient Administration Officer
<u>ENLISTED PERSONNEL</u>	
1	Administrative Non-commissioned Officer
5	Medical Specialists
3	Dental Specialists
2	Pharmacy Specialists
3	Patient Administration Specialists
3	Preventive Medicine Specialists
1	Communications Specialist
TOTAL: 33 PERSONS	

Figure 1. Sabana Grande de Boya Municipal Hospital. A preventive medicine specialist (SSG Joseph Didiego) dispenses toothbrushes and sanitation information to patients waiting in line to be seen in the clinic.



travel time from base camp by convoy over poor roads. A round trip with all equipment was made each day. (For security reasons, all military persons were required to live at the base camp.) The second week consisted of five days in the out

patient clinic of Bayaguana Municipal Hospital, only a 30-minute trip from base camp (Figure 2). In the ten days of clinic operations, 6037 patients were treated (Table 2).

At a site, the medical/dental team must maintain a carefully balanced relationship with the host nation hospital personnel. It must maintain control over people and resources and yet draw on the experience and skills of the host nation staff. Language is always a potential barrier, and two additional bilingual soldiers were recruited from the task force. The team manages all aspects of clinic operation supplemented by host nation workers as available (registration, clinic flow, preventive medicine, and pharmacy). Dental personnel do only extractions; time and resources do not allow for restorations. Portable field dental sets are used. Sterilization was done with cold solutions. Battery-operated head sets (and flashlights) provided lighting.

Our scope of medical service is limited. Seeing a patient for a few minutes on a one-time basis does not permit opportunity for true care. A quick history and physical exam try to establish

one or two problems of concern to the patient for which we have some ability to treat (Figure 3).

Otitis media in a child, respiratory illness in an adult woman, or skin rash in a field worker might be helped. We gave anti-parasitics lib-

erally to children and adults knowing that public health issues make this a futile intervention. The health ministry did not want us to give immunizations because it would conflict with their ongoing program. Surgical cases were simple incision and drainage procedures. We were fortunate that the host nation military provided us with an obstetrician/gynecologist at each clinic as we were in no position to examine/treat these patients. When a complicated patient presented (e.g. suspected tumor, un-

controlled diabetic, or severe hypertensive), we referred the patient to the hospital "emergency room." This represented a very limited option, and we were uncertain of outcome but had no other recourse.

The spectrum of illness encountered is related to several phenomena: language skills, time, and patient percep-

tion, as well as the social/public health influences. History and review of systems invariably evokes a positive response to every question. The patients almost always claim to have headaches, vomiting, pain in every part of the body, parasites, and so forth. Our hosts note that this is perfectly reasonable. Here is a one-time chance to see a doctor who has medications to give away. Regardless of the current chief

Table 2. Patient Care Activity

<u>DATE</u>	<u>LOCATION</u>	<u>MEDICAL</u>	<u>DENTAL</u>	<u>TOTAL</u>
14 - 18 June	Sabana Grande	2596	122	2718
20 - 24 June	Bayaguana	<u>3193</u>	<u>126</u>	<u>3319</u>
10 DAY TOTAL		5789	248*	6037

*467 TEETH EXTRACTED

Figure 2: Bayaguana Municipal Hospital. Crowd control outside the clinic is essential.



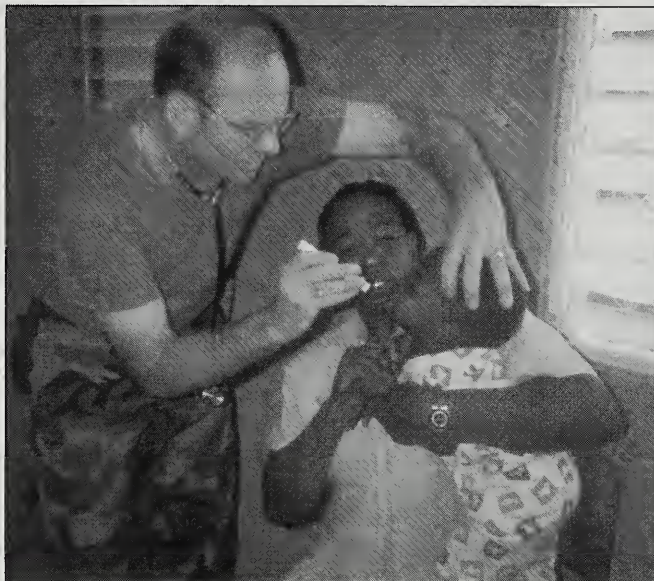
complaint, why not get something for what has troubled you in the past or might come in the future? After filtering this concept, it was apparent that public health/environmental factors naturally dictate prevalent disease: parasites, anemia, dermatological conditions. The people of the area work hard and live without conveniences, so musculoskeletal complaints are logical.

It appeared that a flu-like illness was currently prevalent in the area. This was manifest by fever, cough and myalgia. We quickly learned this was called the "grippe," and I believe two of our nurses contracted it because they became symptomatic at the time of our return trip.

Persons of African descent living in the Western hemisphere, including African Americans, have the highest prevalence of hypertension in the world.² Nevertheless, we were surprised at the incidence of hypertension in women over age 35. Our Dominican physician colleagues said this is very common but didn't tell us if it is related to genes, environment, or diet. The medical literature reports hypertensive retinopathy is more common in Afro-Caribbeans, particularly women, when compared to Europeans.³ Another study, however, found that the

prevalence of hypertension and current smoking rates in Dominicans were similar to Americans and lower than that of Japanese.⁴

Figure 3: Each patient has a brief interview and physical assessment. (COL Todd Guernsey MC is a Pediatric Pulmonologist at Alfred I. duPont Hospital for Children)



The Dominican Republic shares the island of Hispanola with Haiti. People of Haitian ancestry, as well as border crossers, were living in the area and attended our clinics. It is difficult to estimate the HIV incidence, but three men in the small inpatient section of the hospital were suspect (Figure 4).

We had a number of patients both male and female who had symptoms consistent with STDs. These we treated empirically since there was no opportunity for laboratory testing.

Figure 4: Men's inpatient ward at Bayaguana Municipal Hospital.



The children were delightful (as they are everywhere). Half-frightened and half-curious, they soon realize the visit to the clinic is an "event" and that they will receive "prizes" such as a toothbrush, colored pills, and a few cc's of yellow liquid syringed into the mouth (pyrantel pamoate). Respiratory disease, skin problems, and anemia (diet, parasites) were common problems related by the parent.

From the Army's standpoint, there were two significant accomplishments. First, the mili-

tary health professionals of the team acquired an understanding of what it takes to deploy and work in an overseas environment. They better appreciate the medical issues that impact on U.S. troops serving in such an environment and will be better able to care for them. Second, the humanitarian assistance to the people of the Dominican Republic enhances the process of nation building. It is our country's hope that all of the Western Hemisphere nations will maintain democratic governments that improve the standard of living for the people.

For the men and women who volunteered to serve on this medical team, the value of the experience was reflected by their positive response to the question posed on the trip home: Would you do this again? Virtually 100 percent said yes (maybe not next month, but probably next year). This was the first experience overseas for some, and for most, it was the first time they worked in a third-world health care envi-

ronment. Each brought back a better appreciation of how fortunate he/she is to live and work in the United States. All developed admiration for people who live and work in difficult circumstances with few basic conveniences and material goods.

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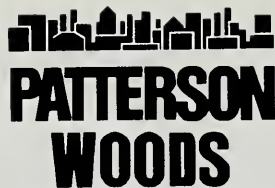
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Ken J. Musi



The Medical Missions of Rafael Zaragoza, M.D.: From Homeland to Hometown

Michael R. Zaragoza, M.D.

Every December, for nine of the past ten years, Rafael Zaragoza, M.D., embarks on a medical mission to his homeland in the Philippines. Dr. Zaragoza, a urologist practicing in Dover since 1964 and past president of the Medical Society of Delaware, joins a contingent of other volunteer surgeons from around the U.S. and Canada to provide surgical care to poor Filipinos in rural, under-served areas.

The Society of Philippine Surgeons in America (SPSA) began the mission in 1990 and continues to sanction the annual trip along with support from local Rotary clubs in Dover and the Philippines. For the past several years, Dr. Zaragoza, a member of the Dover Rotary Club, has been co-leader of the mission along with an Ohio sur-

geon. The two are members of the SPSA which provides the bulk of the participating surgeons, anesthesiologists, and nurses, although a growing number of non-Filipino U.S. doctors and nurses have become part of the contingent.

This dedicated group of volunteers usually travel to remote areas of the country where modern medical facilities are not available and where most of the people cannot obtain adequate medical and surgical care, either because of an inability to pay, or because of insufficient access. Planning the mission takes about one year. After selecting a destination, the group contacts local Filipino doctors, businessmen, and politicians to arrange accommodations and organize the week-long visit.

All mission participants pay their own way including transportation, lodging and some meals. Most of the meals are provided by local

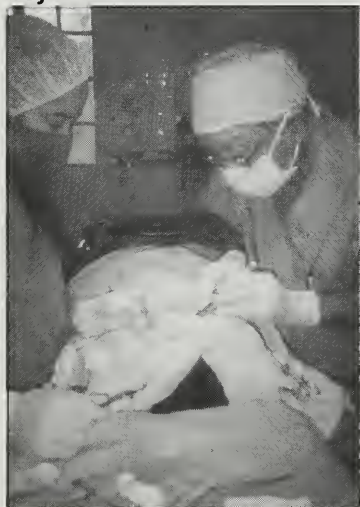
Michael R. Zaragoza, M.D., practices urology in Dover Delaware with his father, Rafael Zaragoza, M.D. He is also an Associate Editor of the Delaware Medical Journal.

Rotary clubs. The group brings with them surgical supplies and medications, most of which are donated by pharmaceutical and medical supply companies as well as Kent General Hospital in Dover.

This year, a group of 12 surgeons visiting the town of Benguel in northern Luzon will complete over 120 surgical cases in a five day period. The team operates twelve hours a day, performing general surgery, plastic surgery, head and neck and urological procedures. Makeshift operating rooms are often small and cramped and typically involve two cases in the same room. Two surgical teams operate separately, but usually share a central suction canister with individual tubing supplying each OR table.

Often encountered are congenital deformities such as cleft lips and cleft palates, which are particularly common due to a lack of prenatal care in women. Touched by Filipino children with cleft

Repairing a cleft lip under local anesthesia in a young Filipino boy.



lip, Dr. Zaragoza learned surgical reconstruction of the deformity from a plastic surgeon in the mission group five years ago. He now performs the procedure regularly during his visits. In addition to urological surgery such as prostatectomy, kidney and bladder stones, and hernias, he has also performed thyroidectomies, cholecystectomies, hysterectomies and various "lumps and bumps" cases.

Two surgical cases at the same time in one operating room due to limited facilities.

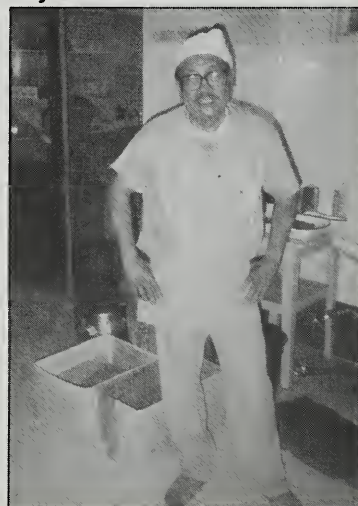


"Most rewarding," says Zaragoza "is the expression of joy and gratitude on the faces of the patients and families after seeing the results of their operations." He remembers repairing a cleft lip in a 13 year old girl who, ashamed of her deformity, had become a recluse and had never smiled. Upon looking in the mirror after her surgery, the girl's face brightened and her mother shared that this was truly the first time her daughter had ever smiled.

Two other young patients, both boys, aged seven and eight years respectively, were so anxious to have their cleft lips repaired that they willingly underwent surgery with local anesthesia since an anesthesiologist was unavailable during the last stage of the mission. "They never cried," recalls Zaragoza, "and they denied pain, but you could see tears in their eyes. The happiness and gratitude expressed by these youngsters after surgery was more than enough to compensate for our long hours on the trip."

The success and satisfaction derived from Dr. Zaragoza's work in the Philippines provided the impetus for bringing his missionary spirit closer to home in Delaware. After attending an American College of Surgeons Officers seminar in Chicago four years ago, Dr. Zaragoza was inspired by a volunteer surgery program in San Francisco and set out to organize a similar program in Dover.

Dr. Rafael Zaragoza after a long day's work.



Under Zaragoza's direction, the Volunteer Ambulatory Surgical Access Program, or VASAP, was begun in November 1995 at Kent General Hospital in Dover with the intent to provide uncompensated, low risk ambulatory surgery for unsponsored, uninsured working patients who would otherwise be unable to afford surgery. Essentially, the program was created to benefit the working poor who "fall through the cracks" because they cannot afford health insurance but earn too much money to qualify for welfare or Medicaid. The goal is to provide early intervention for elective ambulatory surgical cases in order to reduce operative risk and obviate higher treatment costs.

Zaragoza has successfully solicited volunteer physicians and nurses and the support of Bayhealth Medical Center in Dover to donate their time, talent and resources to help those less fortunate in the community. (Table 1) Also lending tremendous support in the endeavor is

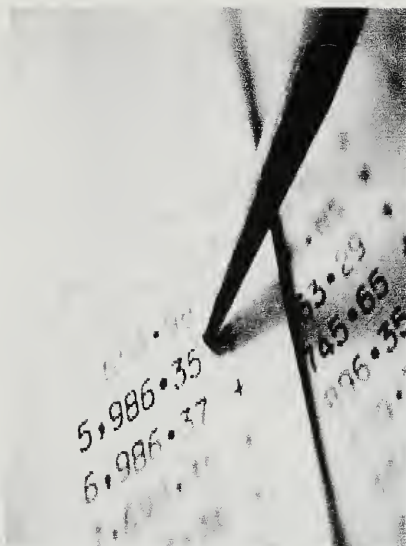
the Dover Rotary club, who founded the VASAP board of directors and incorporated the coalition as a non-profit volunteer organization.

To date, VASAP has performed over 70 surgical cases, or the equivalent of roughly \$500,000 worth of services, at Kent General Hospital. Dr. Zaragoza has begun a low cost health program in Kent County and hopes to duplicate the program in other communities within the state. He gladly welcomes input from other physicians in Delaware.

When asked about his motivation for volunteer work, Zaragoza replied "All I can say is that I have two missions in my life. The first is to raise my family and educate my children, and the second is to share the wealth and knowledge, and gifts of expertise that God has given me, with those who are in need of my services. I have, I think, fulfilled my first mission, and I am in the process of fulfilling my second."

Table 1. VASAP Volunteers

Dr. Rafael Zaragoza	Dr. Sidney Barnes	Janet Faulkner, R.N.	Connie Scott, R.N.F.A.
Dr. Stephen Cooper	Dr. Gary Markowitz	Katie Fortier, R.N.	Pat Simmons, C.R.N.F.A.
Dr. Larry Piccioni	Dr. Anika Alam	Janice Bryan, R.N.	Leslie Hensley, C.R.N.A.
Dr. Henry Kim	Paula Cooper, R.N.	Mary Gardner, R.N.	Janet Clendaniel, C.R.N.A.
Dr. Edward Alexander	Sylvia Hercha, R.N.	Linda Foskey, R.N.	Mary Burgholzer, S.T.
Dr. Bruce Bolasny	Kim Erti, R.N.	Nancy Vasquez, R.N.	John Pearson, L.P.N.
Dr. Vivian Griffin	Joanna Saxberg, R.N.	Charlotte Powell, R.N.	Gene Montano, S.T.
Dr. John Glenn	Sue Lemmons, R.N.	Sharon English, R.N.F.A.	Debbie Scott, Volunteer
Dr. Sam Wilson	Cynthia Vogel, R.N.	Lisa Jenson, C.R.N.F.A.	Tina Tackett, Volunteer
Dr. Michael Zaragoza	Donna Goldsborough, R.N.	Joanna Bates, R.N.F.A.	Eileen Abbott, R.N.F.A.
Dr. Basilio Bautista	Kathy Layton, R.N.	Carl Roosa, C.R.N.A.	Pam Weimers, R.N.F.A.
Dr. Wendy Newell	Terry Schleifer, R.N.	Ginny Behan, C.R.N.A.	Joan Stewart, R.N.F.A.
Dr. Andreas Rauer	Carol Geiger, R.N.	Robert House, C.R.N.A.	Carol Feinour, C.R.N.A.
Dr. Rick Relova	Tina Risner, R.N.	Pat Bosenberg, L.P.N.	Joyce Thompson, C.R.N.A.
Dr. Alex Azar	Mary Ellen Rowley, R.N.	Cathy Callahan, S.T.	Lilly Singh, S.T.
Dr. Glenn Rowe	Judy Mitchell, R.N.	Dorothy Vowels, Volunteer	Martie Snyder, S.T.
Dr. Tom Barnett	Ann Souder, R.N.	Judy Windsor, Volunteer	Judy Reed, Volunteer
Dr. Jason Walther	Janice Camisky, R.N.	Kathy Gazze, C.R.N.F.A.	Linda Parenteau, Volunteer
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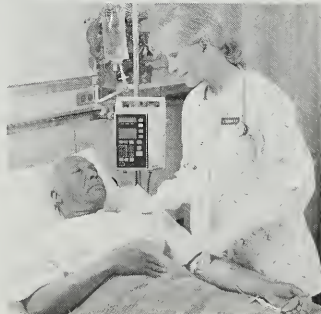
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David Platt, M.D.

In 1979, Kathryn Tschiegg, R.N., a nurse working in the operating room of a hospital in a small town in Ohio, volunteered for a two year tour of duty in the Peace Corps. She was assigned to Hospital de Occidente de Santa Rosa de Copan, high in the mountains of rural Honduras in Central America. She was appalled by what she found. This was a 202 bed hospital, which served a huge surrounding rural area of 500,000 people. Its medical staff were well trained, some in Tegucigalpa, the capital of Honduras, some in the United States. Their medical equipment however, was woefully inadequate, outdated, in poor repair, or missing. They had little or no anesthesia supplies, no respirators, no EKGs, no ultrasound equipment, and a constant shortage of medicines, including antibiotics and pain medications. In one month, she carried to the morgue thirty-one newborn babies who would have lived if they had respirators and antibiotics.

David Platt, M.D., is a retired family practice physician and a member of the Medical Society of Delaware.

After she ended her Peace Corps service, she returned to Ohio and started a campaign with doctors and hospitals to donate their excess samples, medical equipment and supplies for shipment to Honduras. In 1992, she set up a non-profit corporation, CAMO, Central American Medical Outreach, whose function is to collect needed supplies and equipment and to seek volunteers, physicians, nurses, and technicians to serve tours of duty in Honduras, giving care and teaching the local hospital staff how to improve their care. The response was immediately gratifying, and has been maintained. There are many people of good will in this world; the need must be shown to them.

Kathryn Tschiegg, the founder of CAMO, became its full-time executive director. Participation has increased every year. In 1997, sixty-four volunteers from the U.S. brought carloads of medical equipment to the Hospital de Santa Rosa de Copan. They also brought to it, and to the surrounding rural highlands, their expertise in medicine, sur-

gery, dentistry, sanitation, physical rehabilitation, prevention of cancer and of infant mortality. The resulting improvement in health has been remarkable.

In 1995, Cari De Santis, then an administrator at St. Francis Hospital in Wilmington, went as a volunteer to this Honduran hospital. Also from St. Francis were Dr. Carlos Duran and Dr. Anabis Vera-Gonzalez. They were all impressed by the wonders of healing which they witnessed daily. Cari De Santis determined that CAMO needed and must have more widespread public support. She took hundreds of photographs of the people and the place, and selected from them forty-two which caught the spirit of the miracles which occurred daily — written large in the faces of the patients.

She published this book with full page strikingly beautiful black and white photographs, each one faced by a commentary in prose or poetry by Mike Billington, a U.P.I. correspondent. The large photos with the interwoven text make an interesting coffee table style book. All profits from the sale of this book are sent to CAMO.

This is a book about faith, hope, and love. Cari De Santis sums it up well, "That's what this book is really about, faith. Faith in our personal commitments to service, faith in those who can show us the way, faith in a community of strangers dedicated to a common goal, faith in the eternal goodness of humankind, and faith in a loving God, whose plan we cannot know, but who will guide us if we just listen — and look."

Medical Society of Delaware Alliance 1999 Holiday Sharing Card

*Happy Holidays to all of our
friends in the Delaware
Medical Community!*

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Dr. and Mrs. Basilio N. Bautista

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These families have generously contributed to one of the following funds: The AMA Foundation, Delaware Medical Education Foundation, or the DIMER Fund of the Delaware Health Care Commission. Contributions to these funds are accepted throughout the year. Contact the Medical Society of Delaware Alliance for more information.

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Referral Physicians

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Boyle, Kevin, M.D.	Grubbs, Stephen S., M.D.	Newman, James H., M.D.
Cardiac Diagnostic Center	Horn, Richard	O'Connor, Stefan S., M.D.
Carunchio, Michael, M.D.	Ikeda, Satoshi, M.D.	Palmer, T. Shane, D.C.
Chabalko, John J., M.D.	Jonas, Susan K. M.D.	Panzer, Peter B., M.D.
Colbourn, Arthur W., M.D.	Jones, Mark D.	Pasquale, Michael J., M.D.
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Face to Face (800-842-4546, ext. 102)

This program is a joint venture between the American Academy of Facial Plastic and Reconstructive Surgery and The National Coalition Against Domestic Violence. Established to help heal the scars of battery victims, the program has been introduced in Delaware by Paul E. Kelly, M.D., a facial plastic and reconstructive surgeon from Dover. Referral to the program can be accomplished by calling the toll-free number above. If you would like to be a volunteer, please contact Dr. Kelly at (302) 674-3752.

VIP VOLUNTEERS (1992-1996)

The Voluntary Initiative Program (VIP) was a joint venture between the Medical Society of Delaware, the Delaware Health Care Commission and the governor's office. Formed in 1992, VIP functioned as a community outreach program to assist Medicaid patients in establishing "medical homes" with primary care physicians. The following physicians committed to accepting a predetermined number of new Medicaid patients each month.

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